# THE IMPACT OF PROVINCIAL GOVERNMENT FUNDING ARRANGEMENTS ON COMMUNITY-BASED NONPROFIT ORGANIZATIONS PROVIDING MENTAL HEALTH SERVICES

BY

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**The Impact of Provincial Government Funding Arrangements on Community-Based Nonprofit Organizations Providing Mental Health Services**

**BY**

**Daniela Evenson**

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of**

**Master of Social Work**

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## Abstract

In 1993, Manitoba Health implemented the second phase of a reform of its mental health services. One of the elements of the reform included entering into funding arrangements with nonprofit organizations to deliver services. The literature cautioned nonprofit organizations about partnering with government. In particular, there were concerns that their organizational goals would be distorted; their advocacy role diminished; their accessability reduced; their staffing configuration altered; and finally, their structure bureaucratized. Five years after implementation of the reform the writer interviewed the executive directors of 14 organizations that accepted government funding in order to assess the extent and nature of the shift and its impact on the organizations involved. The results revealed that approximately $4 million was awarded to a variety of organizations in exchange for the delivery of a wide range of services throughout the province. In the process, the provincial government became the largest single source of revenue eclipsing all other sources. Initially, the negative impacts appeared to have been minimal. In the long term, stagnating funding levels have reduced the nonprofit organization's ability to recruit and retain staff. As a result, some are reconsidering their continued involvement in the delivery of government-funded services.

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I would like to dedicate this thesis to my parents - Antonio and Olga Dazzan, who had the courage to leave the familiar and venture into the unknown.

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# PREFACE

In 1993, Manitoba Health announced the second phase of the reform of the mental health service system that would subsequently entail the closure of a government program and 65 psychiatric hospital beds. It also included the transfer of funds via purchase of service contracts to community-based nonprofit organizations. In exchange, the nonprofit organizations would deliver a range of new services and programs throughout the province of Manitoba, thereby significantly increasing the role of nonprofit organizations in the delivery of mental health services (Manitoba Health, 1993).

The announcement received mixed reviews from consumer groups, the nonprofit sector and the general public. Although purchase of service contracts (POSC) have been used since the mid 1970's, they continue to be a controversial issue, particularly when involving the delivery of "soft" services such as social and health services. These services are complex, difficult to quantify and deliver, and cumbersome to evaluate and monitor (Hansmann, 1987). Traditionally they have not yielded sufficient profits to entice private forprofit service providers. As a result, these services have remained in the domain of government responsibility.

The concerns regarding the use of POSC stems from the belief that the essential and distinctive contributions of the nonprofit sector would be undermined by the use of POSC, altering the organizations' very nature. In particular, the services delivered by the nonprofit sector would become indistinguishable from those delivered by government or

the marketplace, thereby reducing the available options (Ferris, 1992; Kramer, 1994; Smith & Lipsky, 1993; Panet & Trebilock, 1996).

There has been extensive research into the impact of contracting of municipal services such as garbage collection and park maintenance (Savas, 1982). However, research concerning the impact of POSC's on nonprofit organizations, in general and mental health organizations in particular, has been limited. In addition, the validity of the research that has been done has been questionable due to the variations in nonprofit organizational goals, size, location, client base and modes of intervention, which have made generalizations difficult (Kramer, 1994).

The reform of the mental health services system in Manitoba provided an excellent opportunity to conduct research on the impact of government funding arrangements on nonprofit organizations. The shift in government funding arrangements was clearly delineated by a particular event and was limited to a defined service area (community-based mental health service), thereby reducing the degree of variation in the nonprofit organizations involved and strengthening the validity of the research design (Kramer, 1994). Further, many of the organizations had been involved in funding arrangements for nearly five years providing ample time for concerns to develop. It was also felt that conducting research in this area would be of particular interest to social and health service administrators both in the government and nonprofit sector.

## CHAPTER 1: The Setting - Mental Health Services

In Canada, as in Britain, governments have a preeminent role in providing both institutional and community-based mental health services. In Manitoba, the provincial government annually allocates over $235 million for the provision of mental health services. Of this, approximately 90% is allocated to the provision of institutional mental health services while10% is allocated to community-based services (Manitoba Health Annual Report, 1996). The institutional sector includes acute and extended hospital care, personal care homes (forprofit and nonprofit), mental health centers (e.g., Selkirk and Eden) and forensic services. The community care or community-based sector, included: government delivered community mental health services, medical services provided by doctors and psychiatrists outside of institutions and government funded or subsidized services delivered by community-based nonprofit organizations.

An historic review of the development of the mental health system in Manitoba reveals that the institutional sector has dominated since the turn of the century. Numerous attempts have been made by various provincial governments to develop a more balanced system that would include a more comprehensive community care component. For over sixty years, the provincial government has sponsored a variety of community care initiatives. They have developed psychiatric units in general hospitals, enhanced the use of psychiatric services in primary care settings, created community mental health professionals positions (e.g. psychiatric nurses and community mental health workers),

provided a variety of residential and day programs, decreased the use of mental health centers (e.g. asylums) and finally, increased the role for voluntary groups, friends, relatives, and neighbors in the provision of care for people with mental health problems (Johnson, 1980). Despite all of this, the government still was not able to shift the balance between institutional and community care.

Even though the government's budget for mental health services grew from $96 million (1982) to just under $235 million (1992), the majority of the budget ($206 million) remained allocated to institutional mental health services. Albeit, there were some internal shifts within the institutional sector. As a result of phasing out some mental health centers, their costs dropped. However, the cost for acute and extended hospital care soared from $32 million (1982) to $98 million (1992) (Manitoba Health, Annual Reports, 1982 -1992). It would appear that being unable to obtain treatment in institutions and/or the community, the number of mental health patients who began accessing hospital services increased at an alarming rate. In addition, hospital stays became longer and longer. From 1982/83 to 1989/90, the average hospital stay for mental health patients increased from 21 to 30 days (Manitoba Health, Annual Reports 1982-1992).

In 1988, concerned by escalating health costs and an inadequate community care system, the newly elected provincial Progressive Conservative government launched what was to be the first phase of "a fundamental reform" of the mental health system with the goal of correcting the imbalance between institutional and community care and controlling

health costs (Manitoba Health, 1988). Efforts were made to increase the number and variety of community-based services in the hopes of enticing patients out of the hospital and into the community. Several community demonstration projects were implemented including the Mobile Crisis Team, an acute treatment service for children and adolescents, and a Youth Suicide Information Center.

Yet, by 1992, little had changed. The increased spending for community services had not resulted in a reduction of institutional costs which remained at an all time high. Notably frustrated, Manitoba Health initiated the second phase of reform. The principles were expanded to include increased community and consumer participation, a more diversified range of community programming, and the inclusion of effectiveness and cost efficiency outcome indicators in service delivery (Manitoba Health, 1993). Almost immediately after the announcement, several government programs and 65 psychiatric care hospital beds were closed. Some funds, freed from the institutional sector, were made available to train general practitioners to provide psychiatric service in the community. The remaining released funds ($4 million) were designated to be used to fund nonprofit community organizations to deliver a variety of services, including a crisis line, a supported housing program, a crisis stabilization unit, a consumer run "warm" line and a "safe" house (Manitoba Health News Release, 1993).

## CHAPTER 2: The Reform - From the Institution to the Community

The explanation for the government shift in social policy from an institutionally based service system to a community care system is generally perceived by most social analysts as part of a reformation process which is based on the argument that mental hospitals were not as therapeutic as was originally thought and that people experiencing mental health problems would benefit from being supported in their normal environments (Goodwin, 1990; Ridgeway & Zipple, 1990). Yet, thirty years after coming to this conclusion, conditions for people with mental health problems in the community remain inadequate. Funds for the development of a full range of community-based services have never materialized. Further, although, the number of patients receiving institutional care has decreased dramatically, the cost of institutional care continues to rise while community care continues to be underfunded (Canadian Mental Health Association (CMHA), 1993).

This situation is not unique to Manitoba. Similar patterns are evident throughout Canada, Britain and United States (CMHA, 1993; Goodwin, 1990). So why, after so many failed attempts to implement community care, is the government still committed to this strategy? Several theoretical models have tried to explain this phenomenon.

The Pluralist or Social Democratic Model, as represented by Jones (1972), conceives the government or state as a neutral arbitrator between competing interest groups. The government is called upon to perform a balancing function, mediating

between a variety of groups, classes, and factions. Ultimately, the common good is believed to emerge as various groups and individuals attempt to influence the process. The net contribution is a broad discussion of various policies that reflect the needs and wants of the majority. Essentially it is a description of the democratic process whereby every participant is considered to have power and access to the process (Knuttila, 1987). Therefore:

> community care is not a product of a single process of coherent philosophy but an outcome of a number of trends that have different objectives, emphases and intellectual foundations (Bennet & Mooris, 1983 as cited in Goodwin, 1990, p.5).

In particular, the development of a community care policy is considered to be the result of the three revolutions: pharmacological, administrative and legislative. The introduction of a wide range of psychotropic drugs reduced the need for hospitalization and allowed patients to be released into the community. A series of administrative changes in service provision methods (e.g., development of out patient clinics, community mental health services) ensured patients could seek services in the community. Finally, changes to mental health legislation, afforded patients the right to appeal or review committal orders more frequently, reducing their stay in institutions.

Unfortunately, the Social Democratic Model provides little more than a description of the implementation process of community care (Goodwin, 1990). In fact, as demonstrated by Scull (1984) deinstitutionalisation had already begun prior to the introduction of psychotropic drugs.

The Conflict or Marxist Model, as represented by Scull (1984), contends that the government's agenda was not to reform the service system, but to transfer its responsibilities to the private sector. The development of community care is regarded as the result of "the internal dynamics of the development of capitalist societies" (Scull, 1984, p.134). Scull's thesis states that the development of the welfare system has made community care feasible, that the relative cheapness of this policy as compared to the cost of institutions makes it more desirable to the state, and finally, that the 'fiscal crisis' inherent in capitalism requires the state to reduce its social costs by transferring responsibility to the private sector. Therefore, when the state adopted community care, it was acting only in the economic interests of capital without reference to competing interests.

Although, the Conflict Model may provide an explanation as to why the government chose to implement community care, it still fails to explain why community care has not been fully implemented when it is so desirable to government (Goodwin, 1990).

Critical Theory, as represented by Offe (1985) and Goodwin (1990) offers a third explanation. It contends that the state exists as an independent entity and that it finds itself progressively enmeshed in conciliating two contradictory tendencies within

capitalism: the need to sustain capital accumulation and the need to develop social policy that a majority of the general public will accept as a legitimate response to a social problem.

Even though the state is a separate institution with its own interests and concerns, it still depends on taxation of private capital for income.

> The state lacks power to control the organization of the production process so it has to provide conditions that benefit private capital accumulation in order to safeguard its own revenue (Goodwin, 1990, p.37).

At the same time, the state must also retain legitimacy with the general public by appearing to represent all interests and be responsive to the democratic process.

> The problem for the state, therefore is how to sustain capital accumulation while retaining the allegiance of the general population (Goodwin, 1990, p.37).

In order to achieve this goal, the state must develop social policy that takes into account the conflicting needs and demands of cost, control and legitimization. Cost refers to the cost to the state to provide services versus the level of funding available as a result of the prevailing economic conditions. Control refers to the level of effort that the state must exert to remain in control not only of the service system, but also of the recipients of service, so that they do not to pose a threat to the state. Finally, legitimization refers to the level of support from the public for state action in relation to a particular social problem.

Accordingly, the development of community care policy, can best be understood as a crisis management strategy employed by the state as a means of reconciling these three factors. Developing mental health policy that maintains this balancing act has been particularly difficult for government in light of the present socio-economic context of relative economic decline; increasing acceptance of the rationale that the government needs to limit social expenditures and the apparent rising need for mental health services (Goodwin, 1990; Lightman, 1988).

## Cost

As indicated earlier, institutional mental health care costs have increased dramatically and have been of great concern to government. Even though methodological obstacles have made it difficult to demonstrate, it is widely believed, that community care, in general and funding arrangements with nonprofit organizations, in particular, are more economical alternatives to institutional care. Supporters of community care argue that hospitals and institutions are costly to maintain and replace, and require a large number of highly specialized employees to operate. In addition, they believe most services received by long term patients could be provided just as well, if not better, in more normal settings in the community. Others have agreed with the latter statement, but are guarded in their acceptance of the claim that community care is cheaper. Knapp (1987), for example, speculates that this would be realized through the use of lower paid, paraprofessional, nonunionized, and/or volunteer staff.

## Control

The government's ability to control the health service sector is limited, as Rachlis and Kushner (1989) have pointed out. The real "gatekeepers" are the medical profession.

> They hold the real power. You can't be admitted to a hospital, see a specialist, have a test done, or get a prescription, without seeing a physician. Doctors and doctors alone make the decisions about service their patients receive (p.35).

The argument is that the government will regain control by moving to a community care system and the use of POSC. Certainly the government would find it easier to deal with a decentralized, nonunionized, nonprofit sector rather than the powerful medical establishment. In addition, of the tools (such as laws, regulations, and contracts) available to government to exert control on the service system, contracts have proven to be the most successful (Provan & Milward, 1994). Contract specificity would allow the government to control not only the nature of the service to be provided, but also the quality, location, and consumer of the service. Contracts may also be used to improve program management, to control outcomes, to access necessary services, to manage conflict and/or to avoid resource constraints (De Hoog, 1984; Bachman,1996).

## Legitimacy

The demand for legitimate mental health services has proven to be a complex issue for the state to reconcile. Historically in Canada, there has been little support for the delivery of health service by the forprofit sector. Further, there is no consensus as to what constitutes a legitimate mental health service. The general public, professionals and consumer groups have varying views depending on their definition of the problem.

If a mental health problem is defined as a medical condition, then the most appropriate solution is considered to be medical treatment: institutionalization, use of psychotropic drugs, and consulting a psychiatrist. This solution has dominated the mental health field, and recently has been criticized for not having noticeably improved the quality of life for the majority of patients. The lack of progress had given rise to an alternative approach, that defines a mental health problem as a social condition. This approach locates treatment in a community setting, includes consumers and families in decisions regarding service planning, involves improvements in housing, increased income support, access to therapy, and the provision of educational and employment opportunities (CMHA, 1992; Goodwin,1990; Trainor, Pape,& Pomeroy, 1997). Such varying approaches have made conciliation difficult, and left the mental health field very divided.

The Critical Theory would argue that the state has attempted to resolve the conflict by dividing mental health services into two sectors: treatment and care. Treatment would be the responsibility of the medical profession and would be concentrated in the institutional setting for critical short term periods of time. Care would be transferred to the community and be provided by family, friends and volunteers on a long term basis. In this way, the government hoped to reduce costs and retain legitimacy with its majority stakeholders.

The difficulty has been to garner support for this solution simultaneously from the medical profession, consumer groups and the community. The medical establishment has

been particularly reluctant to adopt community care as it would mean a significant reduction in their role and power in the health sector. They have argued that community care can be implemented but should not come at the expense (e.g. reduction in resources) of institutional care. As a result, the state has encountered difficulty in freeing resources from institutions to implement community care. In addition, there was little evidence that community supports would be forthcoming. As well, based on past experiences with deinstitutionalization in the 1950's and 60's, families, consumers and friends also have been reluctant to support community care, out of the fear that they would be left to provide care without the required resources (Goodwin, 1990).

Realizing services had to be established in the community to maintain their legitimacy with the public, the government made several attempts to encourage the medical professionals and institutions to develop their own solutions. As costs continued to rise and other stakeholders demanded more community services, there was no other choice but to develop aggressive and alternative strategies to free resources from institutions in order to provide the services in the community. This drove governments in Britain, the United States and Canada to close psychiatric beds (65 in Manitoba) and to introduce funding arrangements with nonprofit community-based organizations as a means of gaining control of costs (Manitoba Health, 1993).

As demonstrated, cost, control and legitimacy are not three separate factors. They are invariably linked. For example, if governments attempt to reduce costs to a point

where there are insufficient funds to adequately implement a policy, then the public will withdraw their support (legitimacy) as demonstrated by the backlash to deinstitutionalization. On the other hand, if government spends too much, then support may also be lost, particularly from the business sector. Finally, if government does not maintain sufficient "control" of the people with mental health problems visa-vis the service system, then the public may believe their safety is threatened and withdraw their support of community care. All three factors must be simultaneously reconciled when developing and implementing mental health policy (Goodwin, 1990).

In conclusion, the Critical Theory provides not only an explanation as to why governments have chosen to implement community care, but also why they have encountered difficulties achieving their goal. A further exploration into the nature of nonprofit organizations will assist in understanding the government's motivation in selecting nonprofit organizations as a means of resolving their dilemma.

## CHAPTER 3: The Vehicle of Reform - The Nonprofit Organization

Given the challenge of reconciling the need to contain service delivery costs, retain control and maintain legitimacy, governments have not turned to their own sector or for that matter to the private sector. Instead, they have turned to the nonprofit sector, a sector, which has been difficult to describe, to research or to theorize about because of its diversity (Hatch, 1980; Kramer, 1994).

The nonprofit sector includes a variety of organizational types with differing sizes and levels of organization that are involved in various activities. They are described with many terms including "charitable sector", "voluntary sector", "independent sector", "third sector", "non governmental organizations (NGO's)", "tax exempt sector", "associational sector", "alternative services organizations" and "economic social sector". Each term identifies a particular organizational element at the expense of another (Salamon, 1992). To facilitate our research, a definition that emphasized the basic structure and operations of the nonprofit organization, rather than the organization's purpose and income sources was selected (Salamon and Anheier, 1993). Therefore, an organization is a nonprofit if it exhibits all of the following five key features:

**Formal** - the organization must be institutionalized to some extent. Depending on the country and its legal/taxation laws, this may be signified by a formal charter of incorporation and/ or registration for charitable status. When legal incorporation

is not available, the required formality is provided by regular meetings, table officers, and procedures. In Canada and Manitoba in particular, a nonprofit organization must be incorporated under The Corporations Act of Manitoba. Many also choose to be registered as a charity under The Income Tax Act of Canada (Revenue Canada, 1995).

**Private** - the organization must be separate from other institutions. "Nonprofit organizations are neither part of the governmental apparatus nor governed by boards dominated by government officials" (Salamon and Anheier, 1993, p.14).

**Nonprofit Distribution** - the organization must not distribute profits or other material benefits, accumulated or generated as a result of the service provided, to the organization's members, shareholders, managers or staff. Instead, profits must be retained by the organization to further the mission or goals of the organization.

**Self Governing** - the organization must control its own affairs, with its own internal procedures and forms of governance.

**Voluntary** - the organization must have "some meaningful degree of voluntary participation, either in the actual conduct of the agency's activities, or in the management of its affairs "(Salamon and Anheier, 1993, p.14). In Canada and

Manitoba, a nonprofit organization must have a volunteer board of directors to be incorporated. Its services can be delivered either by volunteers or paid staff.

In the mental health field, a distinction is also made between community-based and institutional nonprofit organizations. This distinction is important because the shift to a community-based service system not only involved the shift from government funded and delivered services, but also from institutional nonprofit organizations (hospitals and mental health centers) to community-based nonprofit organizations.

Community-based services are based on a coherent set of ideas which distinguish them from more traditionally conceptualized mental health service along several dimensions. In a discussion paper issued by The Canadian Mental Health Association in conjunction with Manitoba Health Organizations Inc. and the Social Planning Council (1983), community-based services were described based on several dimensions: location of intervention, level of intervention, type of service delivered, strategies for service delivery, planning source, manpower source, locus of decision making, and finally, etiological assumptions.

However, White (1993) and others discovered that as the term "community-based" has gained legitimacy and dominance, it has been used to refer to a wide variety of organizational types and programs, thereby obscuring the important distinctions between them.

> Autonomous voluntary associations promoting an anti-psychiatry approach and defining consumer rights may be lumped in with organizations contracting with hospitals to provide specialized out-patient service. Both are indeed "community resources" in so far as the community can loosely be considered an environment outside the "total institution" to use Goffman's (1961) term but they have nothing else in common and respond to the needs of different populations in different ways (White, 1993, p. 31-32).

For the purposes of this research, the term "community-based nonprofit organizations" simply refers to nonprofit organizations that are not hospitals. Much in the same manner that Revenue Canada distinguishes between charitable health organizations that are hospitals and "other" health organizations (Sharpe, 1994).

## Nonprofit Organizations in Canada

Not all nonprofit organizations are registered as charities, and as a consequence, very little data exists regarding these organizations. On the other hand, extensive data is available for registered charities, which by definition are nonprofit organizations.

According to Revenue Canada, there are 77,926 organizations with registered charity status in Canada as of June 1999. It is also estimated that there are an additional 100,000 legally incorporated nonprofit organizations (Hall & Banting, 2000). Although there are only a million people in Manitoba, the Office of Consumer and Corporate Affairs of the Government of Manitoba reported there are at least 7,506 active nonprofit organizations in the province (Brown, Troutt, & Boame, 1999). For the past ten years, the number of registered charities has been growing by about 3 percent per year. It can be assumed that the number of nonprofit organizations is also growing.

As such, they play a significant role in our economy (Sharpe, 1994). The Canadian Center for Philanthropy (1994) revealed that over $86 billion flowed through these registered charities in 1993, approximately equivalent to 13% of Canada's Gross Domestic Product. These charities expended $40 billion in salaries and benefits to an estimated 1.32 million people, of which 877,300 were full-time and 444,100 were part-time workers.

> The charitable sector accounts for more of Canada's employment, salaries and benefits than a number of important sectors of the economy including finance, insurance, real estate and construction (Sharpe, 1994, p.14).

The contribution of volunteers is not included in these statistics. The 1997 national survey revealed that approximately 7.5 million Canadians volunteered their time to groups and organizations across Canadian between November 1, 1996 to October 31, 1997. This was an increase of 2.2 million more than the number that volunteered a decade earlier. In total, volunteers contributed just over 1.1 billion hours of their time. This was equivalent to 578,000 full-time year round jobs based on the assumption that 40 hours per week for 48 weeks per year was comparable to a full-time job (Hall et al, 1998). The Prairie provinces appear to be the most fertile ground for volunteering. Over 40% of the populations in Manitoba, Saskatchewan and Alberta engaged in volunteer activity as compared to 31.4% for the national average (Hall et al. 1998).

By private sector standards of revenue, the majority of nonprofit organizations would be considered small, with almost half of all charities in Canada reporting revenue of less than $50,000. An additional third reported revenues of between $50,000 and

$249,999. Only 19% had revenues exceeding $249,999 and 2% had revenues of $5 million or more (Sharpe, 1994).

Nonprofit organizations are divided into various sectors based on the activities they undertake.

> Almost half (45%) or 27,886 of the registered charities were classified in the Religion Sector, 9,635 (16%) were involved in Welfare Sector, and in the Education Sector there were 9,360 (15%). The remaining 24% of the registered charities were involved in the community (14%), health (7%) and other activities (3%) (Sharpe, 1994, p.5).

Nonprofit organizations that provide mental health services are classified in the health sector where a significant split exists between institutional (hospitals) and community-based nonprofit organizations. Almost a quarter (23.7%) of all registered charities providing health services are hospitals, as compared to nearly half (47.0%) providing community-based health services. This includes organizations such as the Alberta Lung Association, Canadian Cancer Society, Canadian Red Cross, and the Canadian Mental Health Association.

In the institutional nonprofit health sector, over a third of all hospital budgets exceeded $5 million in revenues. The remaining two-thirds had revenues of $1 million or more. In comparison, the community-based health sector tended to be smaller with 43.3% having incomes under $49,000, and 33.4% between $49,001 and $499,999. Another

15.1% had incomes between $500,000 and under $1 million. Only 8.3% had incomes in excess of $1 million (Sharpe, 1994).

Hospitals received 30.4% of all charitable revenue even though they comprised only 1.5% of registered charitable organizations. Whereas, community-based nonprofit organizations received 5.8% of all the revenues and comprised 7.1% of all registered charitable organizations (Sharpe, 1994).

Contrary to common belief, nonprofit organizations are not primarily funded by private donations. In 1994, The Canadian Centre for Philanthropy reported that:

> Canada's registered charities, as a whole, receive more than half (56%) of their revenue from governments. Government funding amounted to roughly $49 billion in 1993 with provincial governments providing the greatest level of funding. Most government funding is directed to hospitals (35%) and teaching institutions (34%). Other charitable organizations, which comprise over half of all registered charities, receive only 26% of all government funding (Sharpe, 1994, p.ix).

More recent research has reported similar findings:

> Almost 60% of all nonprofits revenue was reported to in the form of government grants or payments; earned income accounted for 26 % of all revenues and private giving accounted for 14 %. .....Although the sector as a whole is very dependent upon government grants and payments, most government grants and payments go to two types of charities: hospitals receive 37% and teaching intuitions receive 30% ( Hall & Banting, 2000, p. 3).

Provincially, Brown, Troutt and Boame, (1999) reported that the "Manitoba charitable organizations receive roughly 55% of their revenue from government" (p.5).

This is not to say that Canadians were no longer playing a role in supporting nonprofit organizations. In fact just the opposite:

> Approximately 21 million Canadians - 88% of the population aged 15 and over- made donations, either financial or in kind, to charitable and nonprofit organizations between November 1, 1996 and October 31, 1997. These charitable donations took several forms: 78% (18.6 million) made direct financial donations either in response to, or by approaching, an organization: 36% supported charitable and non-profit organizations by depositing spare change in cash boxes usually located beside a cash register at store checkouts: 3% reported leaving a bequest to charitable religious or spiritual organization. In kind donations were also common: 63% donated clothing or household goods and 52% donated good to a charitable organization such as a food bank (Hall et al.1998, p. 13).

## Government Support of Nonprofit Organizations

Governments provide nonprofit organizations with three forms of support: direct, indirect and hidden support.

**Direct government support** of nonprofit organizations occurs in the form of grants, core/global funding, service agreements and purchase of service contracts.

Government grants are funds that are made available to community organizations to encourage the development of alternative community services. Governments provide grants to organizations that they believe best match the government's priorities. The organization's accountability to government is limited. They may be required to submit an annual report providing an account of the organization's activities for the past year and including a financial statement. Otherwise, the organization uses the funds as they see fit (Hudson, 1996; Rekart,1988).

Core Funding/ Global Funding is a form of grant funding whereby "the government contributes towards the operating costs of an organization without necessarily funding a specified service" (Rekart, 1988, p.27).

Service Agreements are written agreements in which the government provides a nonprofit organization with funds in exchange for a particular service. Rather than requiring the organization to apply for funding, the government will often approach an organization based on their reputation. An organization's accountability is limited to providing an activity report and audited financial statement (Hudson, 1996; Rekart, 1988).

Purchase of Service Contracts (POSC) are similar to service agreements, in that they involve a written agreement between government and a nonprofit organization in which funds are provided in exchange for delivering a particular service. POSCs differ from agreements in the level of specificity. The contract may specify not only the type, volume, and consumer of services to be purchased but also expected outcomes. In addition, the contract usually includes an evaluation requirement and is awarded as a result of a tendering process (De Hoog, 1985; Hudson, 1996; Kramer and Grossman,1987; Rekart,1988).

**Indirect government support** includes third party fees, per diem payments, vouchers, housing subsides, income supports, legal and training credits.

**Hidden forms of support** include tax relief for donors, tax exemptions for charities, staff support via secondments, use of public buildings, training of staff and resources (Kendall and Perri 6, 1993). Although, the information regarding indirect or hidden forms of support is limited, these forms of support are considered to be significant.

With regard to direct support, there appears to be a shift in government policy from the use of grants to the use of POSC. The move from a "grant culture" to a "contract culture" has been described as a shift along a continuum from "the theoretically pure transfer defined as a grant to the pure enforceable commercial exchange for specific services defined as a contract" (as cited by Kendall and Perri 6, 1993, p.19). This shift has been "a gradual process whereby the terms and conditions of funding arrangements became more detailed in output specifications and in restrictions on the use of the monies until it is difficult to distinguish the arrangement from the ordinary commercial contract" (Kendall and Perri 6, 1993 p. 19).

The extent of the shift to the use of POSC for delivery of health and social services is unclear. A number of authors (e.g. Moskowitz,1989; Perlmutter and Gummer,1987; Rice,1975; Salamon,1993; Sosin,1990) have identified governments' move to POSC. However, statistical evidence has been very difficult to obtain for a number of reasons: a low response rate from nonprofit organizations to requests for data; a reluctance of governments to provide data; enmeshed data that is difficult to interpret; a lack of valid research; and a lack of funds to conduct longitudinal studies (Kramer, 1994; Salamon,

1994). In addition, the growth of POSC's has been related to a number of government policies and trends including; privatization, decentralization, deregulation and deinstitutionalisation, making it very difficult for researchers to isolate the phenomena (Kramer, 1994). The following is a summary of some of research done in the Britain, United States, Canada and Manitoba respectively.

**The British Experience**

Research conducted by Kendall and Perri 6 (1993) based on Home Office data estimated that 10,000 voluntary organizations received grants directly from a government department and that government expenditures on the nonprofit sector had "an overall growth rate of some 19 percent over the period 1983/84 to 1990/91" (p.22). Their research also produced evidence that fee payments (defined as payments for carrying out specific functions) had increased significantly at the local level but not at the expense of grants.

> The most striking figure here is the doubling of fee payments to the sector by social services committees over the period: the use of specific payments by Social Services Departments to voluntary organizations is on the increase (p.27).

There was a 108% increase in funds distributed as fee payments as compared to an increase of 21.6% in funds distributed as grants during the same time period.

Specific figures regarding the contracting out of mental health care in Britain are not available. However Goodwin's (1990) research on the development of community care in the mental heath field in Britain concluded that:

> With this increased emphases upon non-statutory provision of services, there has been some growth in private and voluntary provision of care in the community. In the 1980's, there has been a rapid expansion in the provision of privately run accommodations for mentally distressed people.... Between 1981 and 1986 supplementary benefit payments for board and room lodging have increased rapidly from a few million pounds to 500 million pounds per annum. (DHSS, Health and Personal Social Service Statistics for England, 1980, 1987 as cited in Goodwin, 1990, pp.192-193).

**The American Experience**

In a survey of agencies conducted by the United Way of America, government funding was listed as their largest source (41%) of income, almost twice the amount of the next largest income source (fees and dues), and four times the amount of the agencies' own fund-raising efforts (10.3%). For mental health agencies, the government's portion of income had increased to 65% of the agencies income (Moskowitz, 1989). In addition;

> Surveys of state wide contracting practices have been completed in Massachusetts, New Jersey, Illinois, and New York, as have surveys of Social Services Block Grants in 36 states; of social services in New York, Chicago, and the San Francisco Bay Area; and of specific programs in child welfare, such as adoptions and family preservation services, aging, Title XX and the comprehensive Employment and Training Act, victim services and mental health (Kramer, 1994, p. 56).

Although, it is very difficult to draw conclusions from the surveys due to the varying nature of the organizations, their size and locations, it would appear that governments in the United States are increasing the use of POSC's as a means of delivering health and social services (Kramer, 1994).

In the field of mental health, there has been significant evidence of the use of POSC's.

> Before the 1950's, states provided most of the services directly. Concomitant with deinstitutionalization, however states began to use mental health purchase of service contracts to arrange for community-based services. Estimates show that about 10 percent of state-funded inpatient and 90 percent of state-funded outpatient and residential services are delivered by non state providers, (Dorwart et al, 1986 as cited in Bachman, 1996).

More recently, in the 1980's, the privatization of government services occurred generally throughout the United States. The policies of newly elected President Ronald Reagan emphasized deregulation, degovernmentalization and the new "federalism" that resulted in ceding back to state governments many responsibilities for social programs that had been carried out nationally.

> This trend affected mental health policy and programs. Under President Jimmy Carter, the federal government had developed plans for expansion of Community Mental Health Centers that were created by Congress as the Mental Health System Act of 1980. This legislation was promptly repealed after the election of 1980 and replaced by new and more comprehensive (but less generously funded) block grants to the state for alcohol, drug abuse, and mental health service. The trend of states to purchase of services fueled continued expansion of private providers and cutbacks in state-owned service (Dorwart & Epstein, 1993, p.128).

More specifically, by 1987, in Massachusetts, "more than 50 percent of all state mental health services (funded through the Department of Public Health) were privately provided" (Schlesinger. et al., 1986; as cited by Dorwart & Epstein, 1993, p.129). Unfortunately, no distinction was made between private forprofit and nonprofit providers.

**The Canadian Experience**

Ismael and Vaillancourt's (1988) review of privatization in Canada concluded that six of the seven provinces studied had made "explicit commitments to the process of privatization of social service delivery. As a result of the variation in the provinces and their social service delivery systems, provincial privatisation policies vary in their style, form and scope (pp. 219-.220)."

British Columbia was identified by Ismael and Vaillancourt (1988), as having developed "Canada's most comprehensive and conspicuous privatization package (p.220)" in which every available mechanism, including POSC's, had been used to reduce government involvement. More specifically, Rekart's (1993) comprehensive review of government funding patterns in British Columbia from 1982/3 to 1988/9 inclusive revealed that funding from all federal, provincial, and municipal government sources represented approximately 80% of the total nonprofit organizations' income. More importantly:

> the proportion of provincial contract funding rose from 39.4% to 52.2% and the amount rose by 137.7%; whereas the proportion of provincial grant funding dropped from 34.8% to 21.4% but its amount rose by 10.4% (Rekart, 1993, p.68).

Canadian research literature provides several examples of government services contracting: correctional services (Gandy, 1984), family services (Hurl and Freiler, 1985), day care (Krashinsky, 1990) and nursing homes (Talman, 1990). Saskatchewan, during the late 1980's and more recently Alberta and Ontario have also embarked on similar privatization paths (Biggs & Stobbe, 1991).

No research has been conducted with regards to mental health services. There were a number of indications that governments would be moving in this direction. Lightman (1988) predicted that in response to poor economic indicators, governments would begin to contract out more mental health services in an effort to reduce costs. In addition, several provinces have identified the need to move to a balanced mental health service delivery system involving the use of community-based services (Macnaughton, 1992; Lurie and Trainor,1992). The assumption being made, is that these services would be contracted out to community-based nonprofit organizations.

**The Manitoba Experience**

Manitoba has a long history of nonprofit organizations providing a range of social and health services including statutory services. For example more than 50% of the provincial funds allocated for child welfare services were awarded to nonprofit agencies (Hudson and Bracken, 1988).

Although, the role of nonprofit organizations in the delivery of mental health services is not as significant as in child welfare, it has increased dramatically since the onset of the reform in 1992. The funds allocated to community-based agencies have grown from just under $500,000 in 1980 - 1981 to $1.7 million in 1989 - 1990, then more than doubled from $2.4 million in 1991-1992 to $6.4 million in 1994 - 1995 (Annual Reports, Manitoba Health, 1980-1995). Unfortunately, the data does not specify if these

funds have been allocated in the form of a grant, agreement or contract nor is more recent comparable data available due to changes in the reporting format.

Provincial government documents detailing the principles of the reform, state that all services provided by government, regardless if they are provided directly or by the nonprofit sector must "adhere to the highest standards of quality and will be subjected to regular outcome evaluation" (Manitoba Health, 1992, p.5). In order for the government to meet this objective, it would require a shift from the use of grants to more contracts.

In an interview, the Executive Director of Canadian Mental Health Association, Winnipeg Region, indicated that negotiations with the Province of Manitoba in 1996 - 1997, regarding the sponsorship of Seneca House, (a safe house for adults with mental health problems), concluded with an official signing ceremony of a legal document by three government officials and three agency representatives. This was markedly different from a previous year, when the negotiations were concluded with the agency receiving a simple one page letter notifying them that their funding proposal had been approved.

Clearly, governments in Canada, Britain and the United States believe that there are advantages to engaging nonprofit organizations to deliver services while retaining the responsibility for that ensuring social or health services are provided to the public.

More specifically, Panet and Trebilock (1996) have pointed out that when government enters into a funding arrangement with a nonprofit organization, it combines the benefits of government financing with those of the nonprofit delivery.

First, nonprofit organizations by definition consist of community members. Therefore, they are in a better position to identify and serve community needs. Their size and level of accountability, as compared to government, afford them greater freedom to engage in experimentation and to design innovative services in response to clients needs (Douglas, 1987).

Second, nonprofit organizations encourage community participation in the development and delivery of services, thereby empowering and strengthening the community. They also allow the community to assume responsibility for their own members and as well as facilitating the development of "the "social capital" necessary for a well functioning civil society" (Panet & Trebilock, 1996 p. 15).

Third, unlike forprofit organizations, nonprofit organizations are not allowed to accumulate and/or distribute profits. This "non-distribution constraint" reduces the incentive to engage in opportunistic behavior (Hansmann, 1987). This is of particular importance in situations where consumers, including governments, are unable to evaluate the quantity or quality of the services provided and their effectiveness. Determining the effectiveness of a service has been particularly difficult in the mental health sector because

of the multiple factors associated with poor mental health, the long time periods required to assess results, and the lack of a consensus regarding what constitutes an effective service. In these circumstances, forprofit organizations would have both the incentive and the opportunity to take advantage of customers by providing inferior service as a means of generating a profit. A nonprofit organization offers consumers an advantage, by means of the "non-distribution constraint" whereby staff does not benefit personally from providing low quality or cheaper service. Therefore, they have less incentive than forprofit organizations to take advantage of the customers (Hansmann, 1987).

Fourth, when governments retain the responsibility for funding, they can "prevent sub-optimal resource allocation decisions" (Panet &Trebilock, 1996, p.19 ) which often occur in the forprofit sector. If nonprofit organizations continue to rely purely on their traditional sources of funding such as donations, their level of funding will be based on the public's perception of who is needy and deserving of assistance. Whereas, if nonprofit organizations are funded by government, the allocations of funds are more likely to be based on the "accumulated information on population need" rather than the public's perception of need (Panet &Trebilock, 1996, p.19).

Finally, contracting out delivery allows government to focus on policy making and while using nonprofit organizations as "mediating structures" to decentralize service provision (Bendick, 1989). This strategy "also helps build public confidence to resist

'load shedding' initiatives which threaten to reduce social services provision to sub-optimal levels "(Panet & Trebilock, 1996, p. 20).

Obviously, these arrangements are potentially advantageous to the government sector, but at what cost to the nonprofit organization?

# CHAPTER 4: Truth and Consequences - The Impact of Government Funding Arrangements On Nonprofit Community-based Organizations

Although, it would appear that there are several significant advantages for governments to engage nonprofit organizations in the delivery of services, a review of the literature anticipated a variety of predominately negative consequences for nonprofit organizations based on the belief that government would adopt a competitive model of administering funding as represented by a purchase of service contract. The concerns included increased financial responsibility for organizations, diluted advocacy roles, distorted organizational goals, decreased client accessability, professionalization of staff, disintegration of the service system, bureaucratization, and finally, a decreased number and diversity of nonprofit organizations. Although each of these concerns will be discussed separately in more detail, it is important to remember that they are interrelated and, therefore, often difficult to differentiate.

## The Financial Implications

Nonprofit organizations have the reputation of delivering programs economically, making them attractive to governments attempting to reduce the cost of administering social programs. On the other hand, nonprofit organizations have longingly observed the level of funding government programs received and have been eager to obtain government funds based on the belief that they would be funded at similar levels.

The assumption was that the increase in revenue would offset the costs incurred in procuring and implementing the contract. Experience has demonstrated that the cost of proposal preparation and implementation requires a substantial contribution of an organization's time and resources that may not always be remunerated.

Ewalt and Cohen (1975) were the first to issue a warning regarding the extensive costs to agencies of applying for and implementing short-term contracts. As they pointed out:

> If proposal-writing, consultation and evaluation for the new program must be provided by existing senior personnel, the availability of senior personnel, and administrators from other programs is diminished. The effect of distractions multiplied by several projects, is clearly felt by line workers who find senior members less available to them. The workers may also become increasingly irritated by competition for space, telephones, and clerical assistance and by the coming and going of new workers as projects are created and die out (Ewalt and Cohen, 1975, p.335).

Costs related to the development of organizational structures to meet the demands of larger, more formalized organizations were also identified as a problem. These included economic costs for consultant reports, redundancy pay, redeployment, and retraining (Deakin, 1994).

More recently, Smith (1994) warned nonprofit organizations that they would experience a "cash flow crisis" simply because most are under capitalized due to their size and the nature of the organizations. Grants normally do not allow organizations to amass equity or reserves, making it difficult to deal with disruptions in cash flow, which are

exacerbated by an unwillingness of the government to fully reimburse an agency's costs under the contract requirements.

Furthermore, Smith (1994) notes that organizations under-estimate costs either out of inexperience or unforeseeable increases in the prices of insurance, rent, utilities and staff or out of fear of not successfully winning the contract. Sometimes incorrect information is given to the prospective organizations during the negotiation process resulting in the under estimation of costs. Amounts adequate at the beginning of a contract may become less adequate as a result of inflation. Following from this, nonprofit administrators are often faced with the prospect of several unpleasant options: terminating the contract, laying off staff, increasing staff workloads, reducing program scope, and/or continuing the contract underfunded or subsidized by external donations or budgets other agency programs.

**Impact on the Advocacy Role**

Along with service provision, many nonprofit organizations provide systematic advocacy on behalf of their "constituent" communities for improvements in services provided by various levels of governments. The concern is that in exchange for providing government funding, nonprofit organizations will be asked to either dilute their systemic advocacy role or loose either their funding, or charitable status (Perlmutter and Gummer, 1994; Smith, 1994). Others believe that although not asked outright to limit these

activities, agencies would be uncomfortable criticizing government officials, programs, and policies when their funding originated from the same source (Manser, 1972; Rice, 1975). Based on theses arguments, there is also a concern that nonprofit organizations would be less likely to provide individual advocacy services, that is, advocating on behalf of individuals to obtain government services or benefits. The dilution of individual advocacy is a particular concern for social and health services consumers, in light of the new fragmented marketplace. Consumers require advocacy assistance in locating and accessing appropriate services (Taylor, 1994).

In Canada, if an organization wishes to be registered as a charity, it makes application to Revenue Canada, Charitable Division, which administers the Income Tax Act as it applies to charities. The Income Tax Act stipulates that an organization

> will not qualify for charitable registration if at least one of its purposes is political. The courts have decided that organizations seeking political objectives, in whole or in part, are not to be considered charities.

Political activities, that could disqualify an organization, include:

> persuading the public to adopt a particular view on a broad social question and attempting to bring about or oppose changes in the law or government policy (Revenue Canada, 1996, p.8).

In other words, in order for a nonprofit organization to maintain its charitable status, it must refrain from systemic advocacy. On the other hand, a charitable status does not preclude an organization from providing individual advocacy. It would appear that it is not only the funding agreement with government that would affect an organization's

involvement in systemic advocacy, but also its desire to maintain charitable status as it applies to the Income Tax Act. An organization must designate its primary activities when applying for charitable status, a process that occurs prior to and independent of an application for government funding.

There is evidence in the literature of the dilution of the advocacy role. Hardina (1990) surveyed 53 social welfare organizations in the United States and discovered that government-funded organizations were less likely than foundation-funded organizations to sponsor self-help advocacy activities and to promote citizen participation. None of the literature reviewed provided any evidence of governments including clauses in service agreements or contracts limiting the right of the organization to advocate nor any discussion of what forces were at play (Hardina, 1990; Smith & Lipsky, 1993). Nor where there any references related to mental health organizations.

This does not preclude organizations from believing that the government would terminate or not renew their contract if they were perceived as being critical of government policies. Based on this perception, some may choose to limit their advocacy role independent of their funding arrangements. Furthermore, governments, concerned with maintaining legitimacy and aware of charitable status requirements, may choose to award contracts only to charitable nonprofit organizations that are aligned to the government's policies, thereby avoiding criticism.

In addition, a reduction in the amount of individual advocacy involvement by an agency may signify a decrease in the need for such activity. Often individual advocacy focuses on accessing government services on behalf of clients. In some situations, funding arrangements provide a nonprofit organization preferential access to other government's services thereby reducing the need for advocacy.

Finally, an assumption has been made that nonprofit organizations play a passive role in this relationship. Not all nonprofit organizations are vulnerable to pressures to limit advocacy. Larger organizations may be able to exert considerable influence as major providers and could use this influence to ensure better services, in addition to their own service agreements (Taylor, 1994). There are also organizations, which based on the belief that their advocacy role would be compromised, choose to decline any government funding and have been very successful in achieving their goals. Other organizations have continued to be openly critical of government and retain their funding.

**Distortion of Organizational Goals**

It is said that government funding can distort an organization's goals by enticing them to concentrate their efforts in areas which may not coincide with their original goals (Perlmutter and Gummer, 1990). The organizations will find themselves compromised not only through direct pressure from a funding source, but:

> through a gradual process of diversion into the areas that are amenable to contract funding and carrying out government objectives (Perlmutter and Adam, 1990, p.157).

Powell and Friedkin (1987) suggest that nonprofit organizations are subject to intense pressure to change as a result of a number of factors: their lack of a single measure for performance, such as profit; goals which are highly politicized and do not lend themselves easily to objective measurement; and their dependency on external sources of funding.

After reviewing ten organizational change case studies, of which nine were nonprofit organizations, Powell and Friedkin (1987) concluded that even though organizations were under pressure, not all organizations and their goals were subjected to the same pressures. Some types of goals were more likely to be displaced than others. Three factors, "political clout, financing, and technical complexity" (p. 191) were crucial.

> Goals that are favored by weak constituents are likely to yield to those favored by stronger ones. Services that are provided to the powerless and the poor are more likely to be supplanted by services for middle income groups who have more political influence. When financial resources are in short supply or controlled by a small number of supporters, nonprofits will be more inclined to change confrontational tactics or controversial programs into more mainstream and/or acceptable approaches. As the activities and programs of nonprofit organizations become more complex and require more sophisticated technical, legal, or financial knowledge in order to execute them, broad-based participation and pluralist governance is likely to decline, and a core staff of experts will come to dominate the organization. These tendencies are not inevitable but they do suggest a particular set of circumstances under which a nonprofit is most vulnerable or susceptible to change in both its mission and its method of operation (p. 191).

In a series of case studies conducted at the McGill University School of Social Work, Shragge (1990) examined the ability of nonprofit alternative service organizations receiving government funding to withstand the pressure to alter their activities. Shragge (1990) came to a similar conclusion as Powell and Friedkin (1987): entering into

partnerships with government does not necessary result in the dilution of the organization's goals.

> The outcome of the relationship with state funding is not only defined by the pressures of the state. Groups bring both their ideologies and traditions, links with similar organizations and other community groups to this relationship, and can resist these pressures. The outcome is not predetermined (Shragge, 1990, p.168).

Shragge (1990) discovered that organizations providing community-based mental health services had been particularly successful in retaining some, if not all of their autonomy.

> If they consciously understand the process, have a coherent belief system and practice, understand the tactical trade-offs and how to make the adjustments while preserving their vision, and have established community alliances and a base of support, then a degree of autonomy is possible (p.169).

Other factors can also reduce the constraints of government funding on the autonomy of nonprofit organizations. Nonprofit organization managers interviewed by Berstein (1991) concluded that they had more autonomy because they contracted with several different government agencies. In addition, the limited number of service providers available to government, the political influence of nonprofit organizations, the administrative and political costliness for government of seeking more control and greater accountability also contributes to limiting government control over agencies (Gronberg, Chen & Stragner, 1995; Kramer, 1994).

Furthermore, Kramer (1994) believes goal deflection is not the concern:

> but a diminished discretion of nonprofit organizations to make certain decisions about types of client, staff and mode of service without having to take into account

> the funding source. This is in addition to having to account via reporting for the funds received as part of a legal contract. In this respect, POSC is not much different than any other grant or gift, except in the degree of its specificity and accountability (Kramer, 1994, p.50).

Kramer (1994) acknowledges nonprofit organizations are more vulnerable. However, he believes, the claims of loss of autonomy may be exaggerated. Nonprofit organizations are accountable to a number of sources: board, bylaws, clients, staff, contributors, and as well as other funding sources which may provide a balance to the impact which government has on the nonprofit organization (Kramer, 1994).

There are those such as Salamon (1994) who reject the notion that organizations should be concerned about being co-opted by governments. In a survey of 3,400 nonprofit agencies, Salamon (1994) found little evidence of distortion and concluded that government funding often allows nonprofit organizations to improve their ability to achieve their mission. Based on trends for public donations, Salamon (1994) concluded that nonprofit organizations would not have been able to sustain their level of service without government funding.

Finally, the loss of autonomy is a concern not exclusive to government funding. Salamon (1989) reminds us that private donors can also attach restrictions, and influence the direction of the organization. In 1997, a $15 million donation to the University of Toronto created intense debate on campus about the potential for influence of private donors over university affairs (The Globe and Mail, February 8, 1997). Under the terms

of the donation agreement, The Rothman Foundation would have the right to request an independent investigation by the Association of America Universities, if annual academic peer reviews at the Faculty of Management indicated that the faculty was not making sufficient progress toward achieving The Rothman Foundation's vision. In addition, the University must establish "an international academic advisory committee (The Globe and Mail, February 8, 1997)." of leading business educators to advise the University on staffing and future directions for the faculty.

**Reduced Client Accessibility**

Nonprofit organizations have traditionally required less independent verification of need for service, relying on self referral and self reporting more often than government agencies. With the introduction of POSC, there is concern that governments would use this as an opportunity to tightened the admission criteria, thereby reducing client accessibility. There was evidence to support this analysis. Rekart's (1993) survey in British Columbia of 133 nonprofit executive directors reported that the majority of the nonprofit agencies surveyed had indicated that the government has stipulated more stringent eligibility criteria as part of their agreements. Research findings were similar in the United States. After surveying 53 social welfare organizations, Hardina (1990) concluded that:

> funding sources play a significant role in determining the use of client access control strategies. Government-funded organizations are more likely than foundation-funded organizations to use income testing to determine eligibility (p. 41).

Literature on mental health nonprofit organizations provided a number of examples of nonprofit organizations restricting services to clients with the likelihood of positive outcomes. This "creaming of clients", is associated with the pressures of accountability - having to produce positive outcomes specified in the contract (Dorwart and Epstein, 1993; Knapp, 1987; Smith, 1994). In short, there is evidence that nonprofit organizations would target services in response to governments funding arrangements.

Although the research literature did demonstrate that government agreements often specified admission criteria, this may not necessarily reduce overall accessibility. The assumption is that organizations can only provide services to clients designated by the government. Often government funding can free other organizational resources to provide services not included in the funding formula.

In addition, much of the literature reviewed presumed that nonprofit organizations are more accessible than government services. Salamon (1989) coined the term "philanthropic particularism" to describe the tendency of some nonprofit organizations and their benefactors to focus on a particular subgroup of the population to the exclusion of others. Prior to the establishment of government supported social and health services, it was common for nonprofit organizations to develop their services for a particular ethnic or religious group such as Catholic Family Services. As a result, certain subgroups of people - gays, the disabled, women, the mentally ill, - found it difficult to establish a niche for themselves in the nonprofit sector and to locate sources of financial support for their

activities. Salamon (1989) also identified a tendency for the nonprofit sector to treat the more "deserving" of the poor, leaving the most difficult cases to the public institutions. In fact, Salamon's survey of 3,400 human service organizations revealed that:

> The poor were the majority of the clients of only 30 percent of the agencies, and that for half of the agencies, the poor constituted less than 10 percent of the clientele (p.112).

**Staffing Implications**

Nonprofit organizations by definition must have a volunteer board of directors. In addition, they may use either volunteers or paid staff to deliver services. Some of the literature advances the concern that nonprofit organizations delivering government-funded services will be eventually forced to decrease their reliance on the use of volunteers and hire staff (Ewalt and Cohen,1975; Rice,1975). This is based on the assumption that clients receiving government services have more complex needs therefore require professional intervention. Furthermore, there is some concern that government would address their accountability and legitimacy needs by specifying that nonprofit organizations hire professional staff rather than rely on volunteers. Finally, government funds would broaden the service of the nonprofit organization, enlarge the scale of the organization and increase administrative demands, thereby limiting the role of volunteers (Knapp, 1987; Smith, 1994).

Unfortunately, much of the early literature that raises the concerns regarding the declining use of volunteers does not clearly indicate why volunteers are preferable. One can speculate that volunteers may be preferred to paid staff because they may be

considered motivated by a sense of responsibility rather than personal gain or that they may be more empathetic to clients problems.

Regardless, Salamon (1989) reminds us there have been problems associated with amateur and voluntary approaches. He coined the term "philanthropic amateurism" to describe the paternalistic approach often assumed by nonprofit organizations in response to the problems of poverty, whereby poverty was attributed to "moral turpitude of the poor". He points out that there are many people in the community, who have not been well serviced by volunteer organizations. Salamon (1989) identified the difficulties associated with sustaining service delivery with only volunteers.

> Care of the poor, the insane, the unwed mother was therefore inappropriately entrusted to well-meaning amateurs and those whose principal calling was moral suasion and religious instruction, not medical aid or job training (p.112).

More recent literature has demonstrated government funding does not guarantee professionals will be employed. In fact, Rekart's (1993) extensive research in British Columbia concluded that agencies were being forced to hire less qualified staff due to insufficient government funding.

> The devolution of service delivery to the voluntary sector in the name of pluralism and empowerment may furnish an environment in which volunteers and lower paid workers are gradually substituted for trained professionals. The Korbin Report (1993) estimated contracted community social service sectors employ 34,000 people, with 20,000 employed directly on government social service contracts. Seventy percent of workers are females and 44% worked part-time. A survey of the 494 organizations revealed that 26% of the agencies were represented by a union making up almost half of the workforce in these agencies. There were wage inequities throughout the sector, raising concerns regrading the standards and levels of care (p.98).

Similar findings were evident in the United States. In an attempt to reduce costs and be competitive, agencies adopted a number of strategies to decrease staffing costs including employing indigenous volunteers, low paid para-professionals, interns, unlicenced professionals, lower-paid part-time staff with flexible schedules, consultants ineligible for benefits, and "subcontractors" or "freelance" para-professionals who accept lower fees in exchange for guaranteed work (Kramer and Grossman, 1987; Kramer, 1994). Schlesinger et al. (1986) ascertained that purchase of service contracting was employed in Massachusetts to circumvent the public sector constraints on hiring, allowing more flexibility in staffing, thereby reducing salaries costs.

> The Massachusetts Council of Human Service Providers has estimated that 10,000 employees in contract agencies received wages 18% below comparably trained employees in the public sector (Schlesinger et al., 1986, p.250).

Furthermore, the Council concluded that the governments' shift to contracting would lead to lower wages, high staff turnover, increased cost to the organization as a result of ongoing recruitment and training needs, loss of service, and finally, coordination difficulties, as well as morale problems. Coincidently, they also noted what appeared to be a trend to the unionization of the nonprofit sector in response to these concerns (Schlesinger et al, 1986).

In short, government funding arrangements provided sufficient resources to enable nonprofit organizations to hire staff rather than volunteers, but not at the level that would allow the hiring of professional staff.

**Decreases in the Level of Integration of the Service System**

Traditionally, the nonprofit sector has been characterized by cooperation and not competition among organizations. Each organization developed its own niche of expertise, ensuring not to duplicate services provided by another nonprofit. Organizations exchanged information and resources, conducted joint programming, referred clients and coordinated case consultations, thereby ensuring an integrated service system. The concern is that the introduction of POSC would discourage cooperation by forcing nonprofit organizations to compete for government funds, thereby decreasing the likelihood of them working together (De Hoog, 1985).

This argument assumes that the primary concern of government is cost containment and not integration of service. As discussed earlier, ensuring an integrated service systems for people with mental health problems has been of particular importance, in light of deinstitutionalisation and decentralization.

> The needs of the persons with severe mental illness are diverse, the services they require tend to be scattered among various community agencies, increasing the likelihood of duplication of some services, creating substantial gaps in others, and causing major problems in guaranteeing continuity of care. The problem is compounded for persons with mental illness because mental illness makes navigating a complex system of service delivery particularly difficult (Provan and Milward, 1994, p. 866).

After having compared the administration of government funds and the level of integration of the service systems, Provan and Milward (1994) concluded that an

integrated delivery system was only guaranteed when strong fiscal control was exercised by state government officials. Because community agencies were so diverse and desired autonomy in their operations, mental health care policy-makers and planners found it difficult to structure a system that provided appropriate incentives for integration without imposing strong constraints that might limit cooperation or minimize the independence of community providers (Provan & Milward, 1994). Of the three mechanisms available to government (laws and regulations, professional norms and contract funding), contract funding was found to be the most effective for controlling service systems (Salamon, 1989; Weiss,1990).

> Integration by force of law or regulation is practical in only a few situations (for instance among the courts, police, state hospital, and a core mental health agency; and is largely ineffective as a primary means to integrate systems of autonomous providers, especially when inter organizational cooperation is important for achieving successful client outcomes. Incentives to integrate through norms are very important in mental health care (Provan and Milward, 1991; Weiss, 1990); but they take a long time to develop and implement and are strongly tied to professional values that may or may not be consistent with current policy need. In addition, norms reflect well-established values and beliefs, making change difficult. In contrast, funding and, particularly its structure, can be both controlled and used as an incentive for voluntary cooperation (Provan and Milward, 1994, p. 868).

Provan and Milward (1994) suggest a service system is integrated when organizations cooperate by providing joint programming, reciprocating referrals and conducting joint case consultations. The level of integration, in turn, is related to several factors associated with contract administration: the existence of monitoring and outcome requirements, the degree of contract specificity and the period of renewal. Kettner and Martin (1990) also demonstrated a relationship between government administration of POSC and the level of competition or cooperation among service providers. They

concluded that governments could encourage competition by tendering contracts, awarding contracts primarily based on price, awarding single year contracts, and finally, including forprofit firms in the contracting process, thereby, discouraging service providers from cooperating with other members of service delivery systems. Whereas, if the opposite occurred, requests for proposals were issued, multi year contracts were awarded and costs were reimbursed, service providers were more likely to cooperate. To summarize, the level of integration will be depended on how government chooses to administer their funding agreements.

**Increased Bureaucracy**

Nonprofit organizations are generally considered to be more innovative, flexible and less bureaucratic than government. It is this flexibility that provides the freedom necessary to experiment and develop services for a specific target group. As Douglas (1987) commented "almost without exception every major social service was originally undertaken by the voluntary sector (p. 48)." The concern is that by becoming dependent on government funding and responding to government's need for accountability, the nonprofit sector will lose these unique characteristics and become more like the government sector (Ferris, 1993; Smith & Lipsky, 1993).

As Thomas (1997) pointed out the term "accountability" is often used loosely and often synonymously with terms such as responsibility, answerability and responsiveness.

For our research purposes, accountability refers to the "obligation to explain or justify how one discharges responsibilities, the origins of which may be political, constitutional, statutory, hierarchal, or contractual. Different origins give rise to different types of accountability - political, legal, bureaucratic, financial, vertical-horizontal, prospective - retrospective etc."(p.144). Theoretically, governments are said to be accountable to the general public via the Canadian constitution, the democratic process and the principles of collective and individual ministerial responsibility. Simply put, the prime minister and the cabinet are assigned the responsibility of developing public policy. The implementation of the policy is assigned to the cabinet ministers who in turn are answerable for actions of their departments. If the public is unhappy with the government's performance they can vote them out of office at the next election

In comparison, a nonprofit organization's accountability is "limited to small interest groups and specific constituencies on whose behalf they claim to act" (Rekart, 1988, p.66). By law, nonprofit charities' accountability is defined as holding an annual meeting, filing an annual return (a fiscal statement), notifying the public of changes in the Board of Directors, and maintaining a minute book of board meetings (Community Legal Education Association, 1992).

> Government programs, therefore, often involve more red tape, cumbersome application requirements, and regulatory control than is common with other forms of financial support... to cope with the financial accountability standards of government programs, the voluntary agency has frequently had to develop internal management process that reduce the agency's flexibility and often threatened its' informal and voluntary character (Perlmutter and Gummer, 1994, p.115).

Even when governments choose to deliver services via POSC, they must still demonstrate that the same level of accountability exists regardless of the fact that they no longer exercise direct control of the service. In essence, government requires the nonprofit organizations to assume responsibility for being accountability. For accountability to be meaningful, government must have the capacity to monitor and assess performance. In turn, nonprofit organizations must provide government with information that is "relevant, clear, timely, comprehensive and diverse" (Thomas, 1997, p.144). In particular, they must provide information that addresses the issues of program, process and fiscal accountability (Robinson, 1971). Program accountability refers to successful achievement of goals designated in the contract or agreement, and requires detailed descriptions of the intervention to be delivered, the outcome to be achieved and the standards to be used to evaluate the nonprofit organization's performance. Process accountability reflects the activities or "deliverables" (i.e., number of counseling sessions provided, number of workshops, number of clients interviewed) rather than the outcomes achieved. Fiscal accountability refers to ensuring monies have been spent as designated in the contract (Rekart, 1988). Essentially, government ensures it has received "the best bang for it's buck". This can be quite a challenge when funds are limited. Often many nonprofit organizations lack access to the financial resources or managerial expertise required to design management information systems, introduce complex accounting systems, acquire computerization, and/or develop extensive policy and procedures. Traditionally, nonprofit managers originating from a social work background do not have

the managerial or administrative background required to respond to these demands (Smith, 1994).

In Britain, Deakin and Walsh (1994) found that the use of POSC was accompanied by an increased use of auditing. In their interviews with agencies, they complained of encountering an increasing number of inspections, audits, reports, and statistical collection requirements, to the degree that they were interfering with their ability to deliver services.

Research in British Columbia indicated that while over 50% of the executive directors surveyed by Rekart (1988) reported that their contracts did not contain requests for the inclusion of standards of service, 47% replied "yes", their contract included standards. Other executive directors indicated that they had established policies and procedures independent of government requirements. Instead, their agencies adhered to a set of guidelines set by affiliated national or provincial bodies rather than government standards. Furthermore, Rekart (1988) found that the amount of required reporting varied among different ministries, although federal and provincial governments required more reporting than municipal governments or the United Way. Consistently, organizations reported that government officials were more concerned with fiscal reporting than they were with the quality of service provided.

Interestingly, more frequent reporting was required when a government department had recently begun to contract out services than when there had been a long established association between the two parties (Rekart, 1988). Similar trends were identified in Britain (Taylor, 1994). Having established themselves as capable of achieving the desired standards, the need for accountability was reduced.

Specifically, in the mental health field, Schlesinger, Dorwart and Pulice (1986) reviewed the use of POSC's for mental health services in Massachusetts and found that the legislators' desire to maintain accountability over mental health care led to the use of "line item" budgets which restricted the ability of nonprofit organizations to transfer funds from one budget category to another. In turn, the organization's ability to respond quickly to the needs of the mentally ill was reduced.

In a national survey of community mental health centers, the majority of which were nonprofit agencies, Dorwart and Epstein (1993) discovered that community mental health agencies, in an attempt to cope with increasing competition and pressures of POSC, were adopting more stringent management practices.

> To increase efficiency, they contracted exclusively with one provider and improved their billing practices. They also sought ways to increase productivity, linking staff compensation to performance, encouraging the use of short term therapies, and increasing their proportion of insured patients (p.97).

The assumption is that nonprofit organizations are becoming more bureaucratic simply because they are receiving government funding regardless of other internal or

external pressures they are subjected to, which may also influence this trend. For example, extensive longitudinal research has demonstrated that as organizations grow and age they naturally become more bureaucratic regardless of their funding sources (Hasenfeld & Schmid, 1989; Quinn & Cameron,1983). In a study of British nonprofit organizations, Kramer discovered, that regardless of size, age and income source, nonprofit organizations had over a period of 15 years, become more professionalized and bureaucratic.

> Even without the strong incentive of public funding, it is characteristic of nonprofit organizations to begin their life cycle as voluntary associations and then to become more complex and formalized (Kramer, 1994, p.53).

The uneven results may be an indication of other factors at play. Two thirds of the nonprofit organizations in North America are less than thirty years old, having been established in response to the growing availability of government funds in the early 1960's (Sharpe, 1994). If Salamon's (1993) conclusions are correct, regarding the decrease in charitable donations, many of these organizations may have not survived without government funding. The bureaucratic process may be a natural extension of aging which could have only occurred as result of the influx of a government support. It also may be a natural process whereby only the organizations that have become increasingly more efficient and effective survive, while those unable to do so have been eliminated. To summarize, there may be a number of factors associated with bureaucratization.

**Reductions in the Diversity of Organizations in the Nonprofit Sector**

The use of POSC's has been promoted in public administration based on the belief that services purchased from the nonprofit sector are more diversified than services delivered by government. Governments' need for accountability would lead to the reduction in the number and diversity of nonprofit organizations (De Hoog, 1985; Sosin, 1990).

As De Hoog (1985) discovered in her classic study of contracting out of human services in Michigan, the administration of contracts was not always consistent with the theory.

> Competition for contracts was minimal. Contracting awards were often without sufficient needs assessment, wide solicitation, or fair proposal review... a key factor in decision-making and reviews has been the preference for professionalism as evidenced by contractors' proposals, reputations, and relationships with officials (De Hoog, 1985, p.449).

Taylor's (1994) review of the British situation indicated a similar pattern of awarding contracts based on relationships. She identified a preference of local authorities to award a single large contract rather than managing a number of smaller contracts.

Sosin (1990) predicted that powerful organizations would continue to receive large appropriations and similar contacts each year, while small agencies on the "fringes" would experience considerable turnover in funding. This suggests that governments often dispense contracts in response to proposals from agencies rather than tendering and that powerful agencies already receiving contracts tend to successfully apply for new awards.

Ironically, it would appear that the system designed to encourage community-based local agencies actually favored the larger more bureaucratic agencies with sufficient staff to manage the contract application process. Kramer and Grossman (1987) observed how the pressure to produce something new, and at the same time meet the requirements of the existing contract, resulted in versions of "mini-conglomerates" where agencies have a number of separate programs administered by one organization. The programs are housed together using similar technologies, but are independent in operation. Each program has its own funding contract but contributes to the operation of the main organization.

Gronberg, Chen & Stagner 's (1995) review of the privatization of the Illinois child welfare system revealed that market factors favored those providers who most closely reflected the state agency's need for specific expertise and which had the power and leverage to bring the most resources to bear on contract negotiations. Of course, this tended to be the larger more established providers.

Specifically related to the mental health field, Schlesinger et. al. (1986) discovered that in the more traditional service areas, pre-existing agencies received much of the contract funding. Their survey revealed that only 20% of all contracts were tendered. Bidding requirements were often circumvented under a number of waiver conditions. The most commonly used waiver was to designate a provider as having "unique capabilities".

In addition, 75% of contract administrators reported that competitive bidding was significantly inhibited by an absence of qualified providers.

**Summary**

Governments have provided nonprofit organizations with several forms of support:

- direct support including grants, core/global funding, POSC's, service agreements,
- indirect support through third party arrangements, and
- hidden support through the taxation system.

Preliminary evidence indicates that the government's direct support for nonprofit organizations have shifted from the use of predominately grant funding to the use of purchase of service contracts (POSC's). Purchase of service contracting represents a more competitive model of administrating funds which includes: an increase in the specificity in the funding documents, a tendering process as well as, an evaluation of the services purchased. Purchase of service contracting with community-based nonprofit organizations is one strategy employed by government to implement a community care mental health system, and reconcile the government's need to contain costs, retain accountability and maintain legitimacy.

Although, there has been a great deal of speculation regarding the impact of POSC on nonprofit organizations, there has been very little reliable research (Kramer, 1994). Concern exists that purchase of service contracting will have a negative impact on the nonprofit sector and its organizations. An initial review of the literature identified the following categorical effects: financial implications, decreased advocacy role, decreased client accessibility, staffing concerns, decreased integration of the service system, increased bureaucratization and finally, the reduction in the diversification of nonprofit organizations.

## CHAPTER 5: The Investigation

The purpose of this research was to explore the changing roles of the government and the nonprofit sector in funding and delivering mental health services in Manitoba. There were two research goals:

1) To describe the nature and extent of provincial government funding arrangements with community-based nonprofit organizations providing adult mental health services in Manitoba.

2) To examine the impact of provincial government funding arrangements on community-based nonprofit organizations in Manitoba.

The research design was based on four factors: the type of research questions posed, the extent of control the researcher had over actual "behaviourial" events, the degree of focus on contemporary events as opposed to historical events, and the unit of analysis (Yin, 1994; Babbie, 1989).

The research questions were both exploratory and descriptive in nature, lending themselves to a variety of research methods. Much of the study focused on "history". As such, the researcher had "no control over and/or access to behaviourial events" eliminating the use of experiments (Yin, 1994). Since the history was recent, having occurred after 1992, observers of the events were interviewed to obtain their perspectives of the events.

Although interviews are chiefly used in studies where individuals are the units of analysis, they can also be used to study organizations as long as the interviews are administered to key personnel and supplemented by other sources of data, such as documents (Babbie, 1989; Yin, 1994).

Based on these factors, the researcher chose two data sources. The primary source was interviews which were conducted with key organizational personnel, in most cases, the executive directors of mental health organizations. As well, an interview was conducted with a government official responsible for the funding arrangement. The secondary data source was a review of several administrative documents. Several sources of data enable the researcher to develop converging lines of inquiry, thereby, strengthening the research design and addressing some of the problems of construct validity (Babbie, 1989; Patton, 1987).

## Unit of Analysis

As indicated earlier, the primary unit of analysis in this study was the nonprofit organization. A great deal of variation exists in this sector. Organizations vary in type, size, age, activity, history and level of development, often making it difficult to generalize. Based on the recommendations of other researchers, the degree of variation in the organizations was reduced through the development of a set of criteria. This method of choosing nonprofit organizations strengthens the research design and facilitates the development of generalizations (Kramer, 1994).

This study adopted a purposive sampling of organizations. In order to be included in the research study, an organization needed to meet the following criteria:

1) be incorporated as a nonprofit organization under provincial legislation,

2) be identified as community-based,

3) be funded by the Manitoba government,

4) servicing adults with mental health problems/mental illness.

In the nonprofit sector, occasionally there are "mini conglomerates", organizations that administer a number of programs to various client groups. In these cases, the research focused on the program specifically providing mental health services rather than the organization as a whole.

**Sample Recruitment**

Based on other researchers' experience, the researcher decided not to rely on traditional methods to identify organizations receiving government funding, (i.e., to ask the government for a list of organizations or to conduct a review of the Public Accounts). In most cases, this has proven to be too time consuming and is imprecise (Rekart, 1988). Instead, the researcher relied on information from the nonprofit sector. The researcher consulted several prominent members of the mental health community and Contact, a computerized data base of all the community resources in Manitoba, to identify organizations that met the criteria.

To ensure that organizations met the research criteria, the organization's status, funding sources and mandate were verified when the researcher contacted the executive director of the organization to schedule an interview. Final verification occurred when a content analysis of administrative documentation was conducted. In total, out of the19 organizations approached to participate, 14 organizations were selected and/or chose to participated in the research.

**The Interview Schedule**

Interviews were conducted with the executive director of each organization, guided by an interview schedule designed to gather both qualitative and quantitative information on the following:

1) A description of key organizational elements: mission, budget, funding sources and trends, number and qualifications of staff and volunteers, client group, relationships with other nonprofit organizations.

2) A description of the funding arrangement: level of specificity in the funding documents, renewal date, level and process of reimbursement, process of tendering/awarding.

3) A description of the impacts of the funding arrangement on the organization's: mission and goals, advocacy role, admission criteria, staff, level of bureaucracy, budget, relationships with other organizations.

A copy of the interview schedule is included in Appendix A. To enhance the criterion-based validity, the researcher utilized some questions from previous studies. Using questions from another study is advantageous in that the findings can be compared to those in the previous study, and the investigator can save time in the construction and pretesting of the questionnaire (Tripodi, 1985).

The interview schedule was pretested prior to the initial interview to ensure the clarity and relevance of the questions, ordering of questions, and length of the interview.

**The Interview**

A copy of the questionnaire was mailed to the executive director of each organization accompanied by the recruitment letter (see Appendix B) detailing the purpose of the study, and requesting an interview. Two weeks after the letters were mailed, the organizations were contacted by the researcher to set a time for an interview. This method was used to improve the response rate (Reckart, 1988; Yin, 1994; Babbie, 1989).

The interviews were administered by the researcher during the fall and winter of 1997. Each interview took an hour and half to two hours to complete and was conducted with the executive director or program manager of each organization. In one situation the position of executive director was vacant so a long-standing board member agreed to be interviewed.

All but one interviewee consented to being tape recorded. Taping the interview allowed the researcher to focus on exploration of the data rather than recording. The researcher took notes in case the tape recorder did not work and when permission to use a tape recorder was not granted. To ensure confidentiality, the tapes were identified with a code and stored in a locked cabinet.

**Confidentiality**

One of the greatest challenges to recruiting organizations for this study was to maintain the organization's confidentiality. The small sample size required the researcher to be particularly careful that every measure possible was taken to safeguard confidentiality. Ultimately, the researcher acknowledged there were limitations.

Prior to commencing the interview, the participant was oriented to the purpose of the study, the amount of time required, the procedures employed to ensure confidentiality of research participants, the procedures employed to ensure research documents are kept secure and, finally, the possible limitations to confidentiality. If they were in agreement, they were then asked to sign a consent form. (See Appendix C for a copy of this form.)

**Bias**

When conducting qualitative interviews, the researcher faces the challenge of controlling for biases and preconceptions. The researcher acknowledged having a number of preconceptions prior to embarking on the research as a result of working in the

nonprofit sector for over ten years. An extensive review of the literature provided the researcher with a more balanced perspective, which is hopefully reflected in the presentation of the literature and the results.

The researcher also adopted a number of other strategies suggested by Miles and Huberman (1994). A careful inventory of the researcher's biases and preconception were included in the research process file/diary prior to commencing the data analysis. Cataloguing these biases acted as a reminder that conclusions should be dictated by the data and not by established beliefs (Tutty, Rothery & Grinnell, 1996).

**Transcribing Procedures**

Initially, the researcher explored the possibility of hiring a professional transcriber familiar with confidential materials. After having difficulties locating an appropriate candidate, the researcher decided to transcribe the tapes herself. In retrospect, this proved to be a good decision as it increased the researcher's familiarity with the materials and aided analysis.

Upon acceptance of the thesis, all identifying information will be destroyed. Transcription material will be retained for future research or publication purposes.

**Administrative Documents**

> Human affairs should be reported and interpreted through the eyes of specific interviewees, and well-informed respondents can provide important insights into a situation. They also can provide shortcuts to the prior history of the situation, helping you identify other relevant sources of evidence. However, interviews should always be considered verbal reports only, as such they are subject to the common problems of bias, poor recall, and poor and inaccurate recording (Yin, 1994 , p.54)

To compensate for this short coming, the researcher included another source of data - administrative documents. The following organizational documents were reviewed:

- Pamphlets detailing the organization's services and mission
- Annual Reports and audited Financial Statements
- Funding Documents

**Data Management**

When conducting qualitative research, it is important to distinguish between a database and the final report. Every research project should strive to develop a formal, presentable database so other researchers can review the evidence directly and not be limited to the written report. A database can increase the reliability of the entire research project (Yin, 1994).

To facilitate the analysis of the large amount of data that the research project generated, the researcher used a series of files to maintain the order of the data without changing its nature. These files included identification, tape, document, content and process files.

**An identity file** contained the information that identified the research participants and the organization's which they represented: address, a telephone number, the code assigned to the organization, a copy of the recruitment letter, and a record of all contacts with the organization. For ethical reasons, the file was kept separate from the data collected from the organizations (Kirby and McKenna, 1989).

**A tape file** contained the audio tape recording identified by a code rather than the name of the interviewee or the organization. Again, in an effort to preserve the organization's confidentiality, the tape files were kept separated from the identity files (Kirby and McKenna, 1989).

**A document file** contained all original research materials: original transcripts of the tape, copies of the administrative documents collected and notes taken. In the process of analyzing the data, only copies of these materials were removed from the document file so that the original context could always be determined (Kirby and McKenna, 1989).

**Content files** contained copies of original data that have been coded and filed into categories for analysis. This process will be described in more detail in the data analysis section.

**A research process file/diary** contained a record of each step taken in the research process. Dated and entered chronologically, this diary included the researcher's

notes, reflections, and minutes of meetings with the committee or advisor during the research process.

As indicated earlier, the interview material was transcribed and administrative documents collected yielding two types of data: quantitative and qualitative.

## Data Analysis

The quantitative data was tabulated and a statistical analysis conducted. Due to non-random sampling, the level of statistical analysis was limited to a non-inferential analysis (Babbie, 1989).

The advantage of employing structured interviews was the quality, and quantity of the data that were generated. The researcher adopted a method detailed by Kirby and McKenna (1989) *in* Methods from the Margins, and Glazer and Strauss (1967), termed the classic constant comparative method. The content analysis technique was selected primarily for its application to historical research. The process consisted of a series of steps:

**Step 1** After the data was transcribed from the tapes, several photocopies of the transcripts were made and divided into manageable portions referred to as "bibbits". Bibbits are "passages from the transcripts, pieces of information from field notes, a section of a document, or a snippet of conversation recorded on a scrap of paper that can stand on its own but when necessary can be located in its original context" (Kirby & McKenna,

1989, p. 133). Each bibbit was coded with the number of the question the bibbit to which it was a response to and the tape code, to ensure that the source of each bibbit could be identified quickly. Next, the bibbits were filed into a series of content files labeled using a number of categories based on the literature review and in response to the data analysis.

**Step 2** Data was filed into categories until the categories were saturated. Determining saturation is an imprecise concept.

> A category is said to be saturated when the addition of new bibbits does not alter the overall complexion of the category. ...When categories are saturated, there is enough information to make statements with a comfortable degree of certainly. Just as categories get saturated, so do substantive theories. When no links between categories emerge the analytical development at that point in that data collection is exhausted. When the analytical files have reached saturation, statements about links between categories can be made with confidence. If no saturation occurs, statements about the tendencies within categories or links between categories cannot be made (Kirby and McKenna, 1989, p.138).

After saturation was determined, the researcher summarized and described the contents within each category. The written summary was attached inside of each individual content file.

**Step 3** After having collected the summaries, the relationship among the categories was analyzed.

> In essence the analysis consists of moving data from category to category (constant comparative) looking for what is common (properties) and what is uncommon (satellites) within categories and between categories. The data is arranged and rearranged until some measure of coherence becomes evident".... "no attempt is made in the analysis to reach a particular level of abstraction. It is the data that determines what analysis is possible and what experiences and concepts can ultimately be described."...."In the method of researching from the margins we

> look to analysis grounded in the data, and to pluralist possibilities to gain meaning, the data is probed for patterns, worked moved and worked again, until patterns present themselves (Kirby and McKenna, 1989, p.146).

**Final Step** Based on Kirby and McKenna's (1989) suggestion, the researcher stepped back from the data, reflected and reworked the analysis where necessary.

Using both quantitative and qualitative research methods proved to be the right choice. Not only did the research generate a significant amount of data, but the different data sources reinforced the findings producing some interesting results.

## CHAPTER 6: The Chosen - A Description of the Government Funded Mental Health Organizations

The mental health community in Manitoba was and still remains a small community in which the service providers are well known to each other. Therefore, it was not difficult to identify 19 organizations that would potentially meet the selection criteria. Of the organizations contacted, one was eliminated from the study after it was determined that the organization was not receiving any provincial government funding. Four others chose not to participate for various reasons. During the recruitment phase, consideration was given to changing the criteria as a means of increasing the sample size. This was rejected because of the concern that increasing the degree of variance among the organizations would make it difficult to generalize results. Even so, it is recommended that the results be treated with caution due to the potential of skewing as a by-product of the variation in organizations' size, function and location (Rekart, 1988).

The following is a summary description of the fourteen mental health organizations which choose to participate in the research.

The mental health organizations were dispersed throughout the province. Fifty percent were located and provided services only in Winnipeg, while 21.4% were located in the city, but provided services throughout the province. Finally, 28.5% were located and

provided a service in the following health regions of the province: Thompson, Norman, Interlake, Parklands, Westman.

All of the organizations received funds from the provincial government but not from the same departments: 92.8% received funds from the Department of Health, while 7.2% from the Department of Family Services and Housing. None of the organizations received ongoing funding from either the federal or municipal governments. Along with government support, the organizations identified 14 other revenue sources. Typically, organizations: applied for grants, accepted donations, participated in fund raising activities, and sold memberships. Surprisingly, nearly half of the organizations were involved in forprofit activities. Some organizations were more successful than others at procuring resources. As such, their revenues varied from under just over $100,000 to more than $1,000,000. The bulk (64.2%) of the organizations had revenues of less than $299,999. Mental health organizations ranged in size from 2 to 25 staff.

The mental health organizations also varied in age. The oldest organization's inception could be traced to the early 1960's. The youngest was incorporated in 1993, in response the requirements of the provincial government funding arrangement. The majority (64.2%) of the organizations were more than 10 years old, while 21.4 % were less than five years old.

All of the organizations provided services to adults with mental health problems, with ten providing more than one service. The range of services included public education, peer counseling and support, information and referral, systemic and individual advocacy, skill teaching, recreational programming, a "safe house", crisis stabilization units, housing and employment programs. None of the organizations provided identical configurations of services. Each organization had developed its own expertise in a particular service area. Although similar services were funded within the province, they were not funded within the same health region. For example, while there were three supported housing programs in Manitoba, only one was funded in Winnipeg.

Finally, over a third (35.7%) of the mental health organizations identified themselves as self help organizations - organizations whose services are exclusively delivered by "consumers", whereas, the remainder (64.3%) of the mental health organizations (which will be referred to as "professional" organizations) delivered services using para professionals and/or professional staff. This distinction was not initially made by the researcher but proved to be important in the data analysis.

# CHAPTER 7: Their Funding Arrangements

The literature has suggested that the relationship between the state and the nonprofit sector is in the process of being transformed. Central to this theme is the shift in the funding arrangements from predominant use of grants to that of purchase of service agreements. This chapter examines the degree to which this has occurred in relation to the study of community-based mental health nonprofit organizations in Manitoba .

There are several administrative features that distinguish funding arrangements: their awarding, documentation, monitoring and evaluation (De Hoog, 1985; Hudson, 1996; Kramer and Grossman, 1987; Rekart, 1988). Ascertaining how the provincial government funding arrangements were administered, facilitated the identification of the type of arrangement involved and, in turn, predicate the impact of the provincial government funding arrangements (Rekart, 1993).

There are three types of funding arrangements: grants, purchase of service agreements and purchase of service contracts. Grants are made available to organizations to cover their operating costs without funding a specific service, awarded on the basis of their match with government priorities, and limited in their accountability. Purchase of service agreements are funded to deliver a specific service, awarded based on reputation, and are limited in their accountability. Finally, purchase of service contracts are funded to deliver a specific service, awarded as result of a tendering process and accountable by

means of an evaluation requirement. Highlighting these distinctions was important for the purposes of this research because we were speculating that not only has the provincial government increased the number of funding arrangements with the nonprofit sector, but it has also shifted from the use of grants to purchase of service contracts.

When asked which description matched their funding arrangement with the provincial government, 42.8% of the executive directors indicated that its funding arrangement would best be described as a grant, and 50% indicated the purchase of service agreement. As the following table demonstrates only one (7.2%) mental health organization described its funding arrangement as a purchase of service contract.

**Table 1 Type of Funding Arrangement**

| Type of Funding Arrangement | Number and Percentage of Organizations |
|---|---|
| Grant | 6 (42.8%) |
| Purchase of Service Agreement | 7 (50%) |
| Purchase of Service Contract | 1 (7.2%) |

On the surface, there does not appear to be a significant shift to the use of purchase of service contracts as was anticipated. The following description of the administration processes provides a more in-depth analysis and some explanation for the executive directors' response.

**The Awarding of Funding Arrangements**

Prior to the reform of mental health services, mental health organizations reported that they approached the provincial government with proposals requesting funds to deliver services. Often these proposals were a systemic advocacy strategy utilized by organizations to demonstrate an innovative service in hopes that the government would incorporate the services within their own service delivery system.

Contrary to the belief that the reform of mental health service would involve a more competitive process for awarding funds, in 92.8% of the situations, the method of awarding funds did not include any form of tendering. Instead, provincial government officials continued to approach individual organizations inviting them to submit a proposal as they had done prior to the reform. If the organization agreed to do so, they would meet with government officials and negotiate the details of a proposal often concentrating on the financial aspects.

Only one organization described an award process that involved competing with other organizations. In this case, several organizations were invited to submit a proposal. After reviewing the proposals, government officials initially chose not to enter into a funding arrangement with any them, stating that they were concerned with the organizations' lack of experience. Eventually, a more established mental health organization agreed to sponsor one of these organizations and the provincial government

awarded the funding arrangement. Within a year, this organization was managing its own affairs independently of the sponsoring organization.

One executive director's observation that "They (the provincial government) have consistently gone to usually well established organizations - they are not keen funding new organizations" was substantiated by other data. Nearly two-thirds (64.2%) of the organizations receiving government funds existed prior to the reform. Half of the organizations were already receiving some provincial government funding prior to the new funding arrangements. Further, two of the newer organizations were associated with national organizations with a long history of mental health service delivery in Manitoba.

There are indications that this may be changing. The last funding arrangement that was awarded (1995) was the tendered funding arrangement. Since then, the provincial government has awarded only one other funding arrangement for mental health services, whereby, they purchased Club House services (Strutt, 1999). In this case, the government also employed a tendering process. This may indicate a trend to the use of more competitive processes for awarding funding arrangements.

After the initial funding arrangements were awarded, all organizations were reviewed annually and were not required to reapply or compete for funding. Several executive directors described the process:

> After you submitted the proposal, they would meet with you and ask general questions about the proposal, usually focusing on the budget.
>
> Unless you changed the proposal or your service significantly, you were not going to negotiate every detail every year.
>
> Originally, when we first met with them, we would negotiate line by line. Now they say 'submit a budget which falls in accordance with this ceiling' and we do.

Sometime after the annual review occurred, organizations received a written notification from the provincial government indicating that the funding arrangement had been approved by Treasury Board. Often the letter arrived after the original agreement had lapsed and well into the new fiscal year. The letter was brief, basically stating the amount of the funding to be received and the applicable duration (the provincial government fiscal year is April 1 to March 31). The process had not changed during the period of time surveyed.

Although, their funding arrangements were reviewed annually, none of the mental health organizations expressed concern about losing their funding:

> Once you were included in the regular budget line, you are not worried from year to year.
>
> Approval? .. Pretty much you know immediately... unless we are asking for too much.

As was the case in Rekart's (1993) research, most executive directors interpreted the automatic renewal as a sign that the provincial government was satisfied with the services that they were delivering. This view was supported by research. None of the

interviewees could cite a case of a funding arrangement having been withdrawn or terminated.

To summarize, in the majority of situations, the provincial government awarded funding based on an organization's reputation for delivering services to the community rather than a tendering process. Even when arrangements were tendered, an organization's reputation was considered. In addition, once organizations were awarded funding, they were not required to compete with other organizations to maintain their funding.

This lack of competition may be associated with a number of factors. There were not many organizations capable of, or for that matter, willing to provide mental health services nor were there any organizations providing the exact same service. Tendering and awarding contracts yearly can involve disruptions of service and affect the government's ability to guarantee continuity of service. There were also significant costs associated with tendering, particularly, if capital costs were involved. Finally, the government may have also wanted to control who received a funding arrangement as a means of ensuring that the arrangements were distributed equitably amongst the various organizations in the community. This was particularly true for self help and professional organizations. Based on these findings, clearly cost was not the only factor considered by the provincial government when funding arrangements were awarded.

## Funding Arrangement Documentation

Prior to conducting the research, it was assumed that documents detailing the funding arrangements between the provincial government and organizations would vary according to the type of arrangement. More specifically, the documents describing a purchase of a service contract would be more detailed than documents describing an agreement or a grant with particular reference to the amount and kind of services purchased by government and expected outcomes.

For 12 of the 14 respondents, the funding documents were the same, regardless of how executive directors described their funding arrangement. They consisted of two items:

1) a copy of the completed Funding Information Requirement Package which was submitted annually to the government (often referred to as the funding proposal by interviewees), and
2) the letter from the provincial government acknowledging the approval of the funding arrangement.

### The Funding Information Package

The Funding Information Requirement Package (FIRP) consisted of a multi-paged form which according to one executive director, "when you have completed answering all the questions, basically that would be your proposal or year end report." (A copy of the Funding Information Requirement Package is included in the Appendix D).

The FIRP package was divided into three parts. Part A requested basic information about the organization and its structure including a legal name, mailing address, organizational purpose, geographic area of operation, a list of the names of officers, board members, board committees and their members, the name of the executive director, an organizational chart, and finally a list of operational locations.

Part B of the FIRP focused on gathering "detailed program information for all programs where Manitoba Health funding was being requested for that fiscal year". The organization was required to provide a description of the target population, needs addressed by the program, program objectives and their intended results, program activities, program initiatives, plus a list of other organizations that offered similar or complimentary services and their relationship to the program. Finally, the applicant was required to list all programs operated by the organization and their funding sources.

Part C of the FIRP package required the organization to list all sources of revenue and program expenditures, plus submit a copy of the organization's annual report and audited financial statements no later than three months after their year end.

**The Approval Letter**

The second funding document was the "approval letter", a one page document that notified the applicant that their request had been approved, the amount of funding they were to receive and the applicable time period.

Surprisingly, one organization had no funding documents. When asked for a copy of their written document that detailed their funding arrangement, the response was:

> It's hard to know which details were included because there is not much codified. Technically, there is no written agreement. What is there is, is simply precedent established prior to provision for service.

Another organization had only recently developed a written agreement even though they had delivered mental health services on behalf of the provincial government for more than seven years:

> We didn't have a contract or agreement until three years ago. At that time considerable amount of time was spent formalizing the existing agreement, the details, goals, objectives, funding levels.

Only one organization had a more a detailed document than described. In this case, the funding arrangement involved the provincial government purchasing property on behalf of the organization. The additional details delineated responsibilities related to property: insurance, repairs, upgrading, taxes, utilities, and ownership.

In short, the documentation required by those describing their funding arrangement as a grant, a purchase agreement or contract was the same. Rather than differentiating the funding arrangements, government officials were more concerned with ensuring that all of the organizations had standardized funding documents, thereby increasing their overall level of accountability.

**Monitoring Funding Arrangements**

In relation to monitoring it was assumed that the level of monitoring would differ with the type of funding arrangements. Specifically, contracts and agreements would be more closely monitored than grants. Plus, the level of monitoring would be demonstrated by the number and kind of reports organizations were required to submit and the number of meetings with provincial officials.

Contrary, to this assumption, nearly all of the organizations (92.8%) submitted only one report per year which consisted of the FIRP. After having submitted their annual report, the executive director would meet with provincial government officials to review the information provided and discuss their budget requests for the coming year. No other formal meetings regarding the funding arrangements occurred although, most of the Winnipeg-based organizations reported having numerous informal contacts with provincial governments throughout the year:

> We met with them at least twice a year, once a year officially and once a year unofficially.
>
> We stay in touch with them (government officials) all the time, there is not a week that goes by that I don't speak to someone in government, I sit on endless committees, groups, councils.

Surprisingly, organizations reported that they often sought opportunities to have contact with government officials:

> If you waited for government to come to you, you would be dead and buried before they found out. You have to go to them, it has been a very active process. You have something they want... that has been of demonstrable use to them.

When a provincial government official was asked why more formal monitoring did not occur, the response was that it was not necessary because they received a wealth of information regarding an organization's performance through their informal contacts:

> There isn't a day that goes by that we don't get a call from a consumer, or family and friends, or other service providers about the services these organizations are providing.

Unfortunately, there was no discussion regarding how this information was to be incorporated into the annual review.

More rigorous monitoring may not have been deemed necessary because of the nature of the relationship between the nonprofit organizations and the provincial government. As Rekart (1993) has pointed out - the tone of the relationship is often established by the negotiations preceding the awarding of the funding arrangement. They provide government officials an opportunity to articulate their expectations and ensure that the organizations are willing and prepared to meet them.

In the case of Manitoba, the majority of nonprofit organizations and provincial government officials worked closely on various committees during the implementation of the reform providing the provincial government not only an opportunity to acculturate organizations to their expectations but also to assess the nonprofit organization's ability to deliver services. In doing so, the provincial government reduced the need to monitor. In addition, by relying on community reports rather than their own monitoring mechanism, the provincial government shifted some of the responsibility of monitoring back onto the

community rather than incurring the cost of doing so. This provides an example of how the government reconciled their need to contain costs and still maintain their legitimacy.

**Evaluating Funding Arrangements**

Finally, the researcher assumed that the funding arrangements, particular the purchase of service contracts, would require an evaluation to be conducted, as indicated in the reform documents:

> Within Manitoba's restructured health system, all major health services, interventions and procedures will be monitored and evaluated in terms of health outcomes (Manitoba Health, 1993, p.3).

The reality was substantially different. At the time the research was conducted, none of the services funded by the reform had been evaluated as a result of their provincial government funding arrangement. In fact, only three organizations had conducted a formal evaluation of their services since their inception. (Because several multiple service providers have often had multiple funders with different requirements, services are not necessarily evaluated all the same time). The lack of evaluation activity was remarkable considering that most of the mental health organizations were in operation for more than ten years.

Although many of the organizations may not have completed a comprehensive evaluation, all of them had implemented one component of an evaluation process notably, management information systems. Often this was in a response to a request from the provincial government, via the FIRP, that an organization report "outcomes" or a

"comparative output statistics" which could be used as some "criteria for measuring the effectiveness of the programs" (Manitoba Health, 1993, p. 4).

Unfortunately, the majority (85.7%) of organizations reported data that could be best described by research standards as input or process objectives or program activity statistics rather than outcomes. An outcome statistic should measure the impact that the organization's service had on its target population. Examples of outcome indicators are rates of hospitalization, levels of client skill functioning, and level of client satisfaction (Gabor, Unrau & Grinnell, 1998; Rossi & Freeman, 1993). Typically, the data collected by organizations reflected the type of service they provided and their target population.

Self help organizations typically provided, public education, peer support, and information and referral services targeting the community. Accordingly, they reported:

- the number and kinds (information or crisis) of phone calls answered,
- the number of public education programs provided,
- the number of displays presented, brochures and information packages distributed,
- the number of people attending peer support sessions.

The data was collated from monthly activity reports submitted by staff.

The "professional" organizations typically provided employment and housing, psychiatric rehabilitation, and counseling services targeting the individual. Accordingly they reported:

- the number of individual files open, closed or transferred,
- the sources of referrals,
- demographic information as it pertained to the individual,
- the type and amount of service received - service coordination, rehabilitation, support, functional assessment, skill teaching.

The data was collected from intake forms and by staff using a daily activity recording tool and submitted monthly.

Client/consumer satisfaction was the only outcome indicator consistently employed by both types of mental health organizations. Exit interviews, membership surveys, follow up interviews, or annual client satisfaction surveys were administered by ten of the organizations. Self help organizations were more likely to rely on client satisfaction as an outcome indicator citing its congruence with their organizational values as the reason for employing this indicator.

There were three other examples of organizations collecting outcome data for evaluation purposes. One organization conducted pre and post assessments of clients' skill level of functioning as a means of demonstrating the effectiveness of the life skills course. Remarkably, two organizations that provided psychiatric rehabilitation had

developed sophisticated evaluation processes incorporating multiple outcome measures. Not only did they gather data on hospitalization rates, education and employment levels but their clients were surveyed regarding their levels of satisfaction in a variety of life domains. Further clients' skill functioning was assessed pre and post service. This data was correlated with amount and type of service delivered. What was so remarkable is that all this was achieved with limited technical assistance or funding from the provincial government.

In fact, it is this consistent lack of financial and technical support for evaluation initiatives by the provincial government that was the reason cited most often by executive directors for the absence of well-developed evaluation systems. When the original funding arrangements were in negotiation, mental health organizations were told that funds were not available for evaluations, in contradiction with provincial governments documents. More importantly, the provincial government appeared unable to provide the technical assistance or direction necessary, as these comments suggest:

> A problem with the reform is they (government officials) talk about a number of things... service deliverables... days of deliverable service... but don't even specifically ask about improvements to individuals, such as, has this individual learnt this skill? or 75% of this skill?
>
> The evaluation systems of the programs are loosely defined, not as detailed as one would naturally assume would be. If I were investing in a program I think I would be a lot more thoroughly to ensure I was getting the results needed.
>
> We chose to implement a MIS using surplus funds because government were saying they wanted us to be more accountable - but they didn't help us figure out how to do it.. nor have they provided the funding to do so.

> Government officials were not willing or maybe unable to tell us how to proceed. We're unable to reach an agreement about what outcomes measure we should use to evaluate programs.

Technically, inadequate program design (evaluability) proved to be an obstacle to evaluation. Program objectives need to be operationalized to conduct a meaningful evaluation (Gabor, Unrau & Grinnel, 1998). Many of the original funding proposals submitted by organizations and approved by government officials, did not detail the outcomes expected. Often funders and providers were not in agreement as to what the impact should be of a service or the length of time or amount service that should be provided before an impact was expected. In addition, typical of government funding, similar services were not funded under similar circumstances, thereby making the establishment of standards and comparisons difficult.

This, of course, assumes that the provincial government had the capacity to evaluate and monitor the contracts. A recent transfer of government delivered services to a regional health authority revealed that the provincial government management information system, as it relates to mental health services, was unable to produce even the most basic statistics.

By not providing any financial or technical support, essentially the provincial government relinquished its responsibility for evaluation and thereby its accountability, to the community. The community acknowledged their responsibility:

> You basically evaluated your program in the way you see fit to evaluate your program.
>
> We took the initiative. It was us leading them rather than them leading us.

Fortunately for the provincial government, mental health organizations were willing to accept this responsibility of ensuring their services were of high quality, as manifested by the amount of evaluation activity that occurred without their support. Consistently, organizations articulated their desire and willingness to be evaluated, not in response to government demands to do so but rather based on their commitment to serving their community. This comment, made by an executive director of a self help organization, demonstrates their willingness:

> We take the responsibility very professionally, we don't take it for granted that the funding will be here. A concerted effort is made to demonstrated outcomes and quality of services, at least that's my philosophy and the philosophy of the board of directors. I'm accountable to the vision and the stake holders who are helping make this possible.

Other comments also demonstrated his commitment:

> It's like a marriage - your partner is expecting you to keep your promise and that you would do what you said you would do.
>
> They reminded us. The onus is on us. You could easily waste the money, falsify the documents, and I don't think that government has any real way of ensuring that you are credible and that concerns me at times.
>
> Its important for the association to maintain standards... to make sure we deliver services that are acceptable or that our staff are (meeting standards) when management are not around... still promoting the standards set by the association.

Essentially, the provincial government relied on the nonprofit organizations' sense of responsibility and commitment to their communities as the driving force behind evaluation initiatives, enabling them to maintain their legitimacy without incurring the cost of providing the financial and technical resources.

To summarize, even though the majority of the executive directors chose to describe their funding either as a grant or purchase of service agreement, an analysis of the awarding, documentation, monitoring and evaluating revealed that the administration of the funding arrangements did not vary substantially. Predominantly, funding arrangements were awarded based on reputation even when they were tendered. Documentation consisted of standardized forms regardless of type of the funding arrangement. Formal monitoring involved an annual review process that did not include competing or fear of termination. Finally, although services were to be evaluated, the provincial government did not pursue this matter aggressively. Instead, they relied on the organization's skills and resources.

Having reviewed all aspects of the administration of the funding arrangements, we have found that there appears to be very little difference how the arrangements were administrated. So what would account for the difference in the choice of descriptions by the executive directors? To answer this question, the researcher explored the relationship between particular organizational characteristics and the funding arrangements. The first characteristic examined was an organization's age based on the

assumption that older, more established organizations would be involved in purchase of service agreements and contracts. As the following table demonstrates, there appeared to be no relationship between type of funding arrangement and the age of the organization. This was consistent with Brown, Troutt & Boame's, (1999) research findings of 72 nonprofit organizations in Manitoba.

**Table 2 Type of Funding Arrangement by Age of Organization**

| Type of Funding Arrangement | 0-5 years | 6-10 years | 11 + years |
|---|---|---|---|
| Grant | 2 (40%) | 1 (100%) | 3 (37.5%) |
| Purchase of Service Agreement | 3 (60%) | 0 | 4 (50.0%) |
| Purchase of Service Contract | 0 | 0 | 1 (12.5%) |

The size of budget was the second organizational characteristic examined based on the assumption that the larger organizations would be allocated purchase of service agreements or contracts. Again as Table 3 demonstrates, there does not appear to be a strong relationship between the type of funding arrangement and the size of organization's budget. This was also supported by Brown, Troutt & Boame's (1999) research.

**Table 3 Type of Funding Arrangement by Budget Size**

| Type pf Funding Agreement | $0 - 299,999 | $300,000 - $1000,000 |
|---|---|---|
| Purchase of Service Contract | 0 | 1 (20%) |
| Purchase of Service Agreement | 5 (56%) | 2 (40%) |
| Grant | 4 (44%) | 2 (40%) |

The final characteristic examined was the type of organization. Unexpectedly, there was a relationship between type of funding arrangement and the type of organization as Table 4 illustrates. Of the mental health organizations that described their funding arrangement as a grant, two thirds were "self-help" organizations. Whereas, of the mental health organizations that described their funding arrangement as purchase of service agreements or contracts, the majority were "professional" organizations.

**Table 4 Type of Funding Arrangement by Type of Mental Health Organization**

| Type of Funding Arrangement | Self Help | Professional |
|---|---|---|
| Grant | 4 (80%) | 2 (22.2%) |
| PSA / Contract | 1 (20%) | 7(77.7%) |

We can only speculate as to why professional organizations would be more likely to describe their funding arrangements' as purchase of service agreements rather than grants. The type of service they provide may be a factor. Self-help organizations are more likely to deliver public education targeting the community whereas the professional organizations deliver a specific service targeting individual clients. Or it may simply highlight the problem of a dissonance between language and practice whereby the language does not necessary reflect the administrative process. This issue is not limited to this particular situation but prevalent in much of the literature. This is particularly true with reference to the use of the term "purchase of service contract". Often funding arrangements are referred to as purchase of service contracts even when the administrative process necessary are not present, in particular, a tendering process has not been

employed. Regardless, it is clear that self help organizations are more likely to describe their arrangements as grants while professional organizations described theirs as purchase of service agreements, even though, there appears to be very little difference in how their funding arrangements were administrated.

Since the funding arrangements were administrated similarly and the amount of competition was limited, we can only conclude that the provincial government was striving for a partnership model rather than a competitive model of administration of their funding arrangements.

> Government officials pursuing a partnership model:
>
> seek to strengthen the working relationship between themselves and other human service agencies, be flexible and compromising in the development, negotiation and administration of contracts, be cautious in experimenting with different modes of service delivery, promote specializations among contractors, and make contracting decisions based primarily on concern for the stability and maintenance of the service system (Kettner& Martin, 1987, p. 30).

As such, we can expect that the impact of entering into a funding arrangement would be considered by the nonprofit organizations as a more positive experience than if the provincial government had chosen a competitive model of administration.

## CHAPTER 8: Truth and Consequences - Revisited

The literature review and the description of the existing funding arrangements provided in the previous chapter, suggests that the consequence of entering into a provincial government funding arrangement will not be as negative as initially anticipated. The following is a review of the results of the in-depth interviews with the executive directors and the accompanying documentation.

### Financial Implications

Initially, the researcher had hoped to analyze budget trends over five years to determine the impact of provincial government funding arrangements. Unfortunately, comparable data was not available. The expectation that annual financial statements required by Revenue Canada would result in consistent formats, proved not to be true. For example, some organizations' fiscal year ended December 31, while others had converted to the government fiscal year - April 1 to March 31. More importantly, gaps in the data existed. Mental health organizations either were unable to or chose not to make the data available. Therefore, the following analysis is based on audited financial statements provided by the organizations for the 1996-1997 fiscal year. The analysis includes an exploration of the impact on the size of the organizational budget and the number and distribution of revenue sources.

**Budget Size**

Organizations in Manitoba's mental health, nonprofit community varied in size. The largest organization had an annual budget in excess of one million dollars while the smallest budget was just over $100,000. This is comparable to other Manitoba health nonprofit organizations whose budgets ranged from $6,000 to $1,600,000 (Brown, Troutt & Boame, 1999). As Table 5 demonstrates, even though there was not a shift in the type of funding arrangements, there was a significant shift with the influx of provincial government funds. Prior to the reform, 86% of the organizations reported budgets of less than $300,000. After the reform, only 64.2% reported budgets less than $300,000.

**Table 5 A Comparison of Budget Size Before and After the Reform**

| Budget Size | Before Reform | After Reform |
|---|---|---|
| $ 500,000+ | 1 (7.2%) | 1 (7.2%) |
| $ 300,000 - 499,999 | 1 (7.2%) | 4 (28.5%) |
| $ 0 - 2 99,999 | 12 ( 85.6%) | 9 (64.2%) |

Clearly, government funding of nonprofit organizations has had a major impact on their budgets. The extent of the impact will become evident further on.

In comparison to all charities in Canada, the mental health organizations tended to be larger. All reported revenue of more than $50,000, whereas almost half of all other Canadian charities reported incomes less than $50,000. Community-based mental health organizations still continued to remain significantly smaller than hospital-based mental health organization. Only one (7%) organization's budget exceeded a million dollars

whereas over a third of hospital-based nonprofit organizations reported $5 million or more in revenues, and 65% reported revenues of $1 million or more (Sharpe, 1994).

A comparison of the types of mental health organizations revealed that professional organizations tended to be larger than self help organizations. Fifty-five percent of professional organizations' budgets were over $300,000 as compared to only 16.7% of the self help organizations. As indicated earlier, this may be related to the type of service they were funded to deliver.

**Table 6 Budget Size by Type of Mental Health Organization**

| Budget Size | Self Help | Professional |
|---|---|---|
| $500,000 + | 0 | 1 (11.1%) |
| $400,000 - 499,999 | 0 | 2 (22.2%) |
| $300,000 - 399,999 | 1 (16.7 %) | 1 (22.2%) |
| $200,000 - 299,999 | 3 (50 %) | 1 (11.1%) |
| $100,000 - 199,999 | 2 ( 23.4%) | 3 (33.3%) |
| $0 - 99,999 | 0 | 0 |

Organizations delivering services in rural areas tended to have larger budgets than those providing service solely in Winnipeg. Fifty-seven percent of rural organizations had budgets over $300,000 as compared only 14% of organizations providing services in Winnipeg. Often, the rural organizations were the only mental health service provider in the community and therefore were more likely to be funded to deliver multiple services, accounting for the difference in size.

**Sources of Revenue**

It is important to be aware of the sources of funding and different proportions of funds from their respective sources in order to understand the evolution and present state of the relationship between the voluntary sector and the government (Rekart, 1996).

Mental health organizations reported revenue from a variety of sources:

- provincial government
- federal government
- municipal government
- United Way
- foundational grants
- lottery funds
- sale of goods or services
- fund raising
- donations
- donations in kind
- volunteer services
- memberships
- interest on investments
- GST rebates

Table 7 shows the distribution of the number and kinds of revenue sources reported by organizations. It is important to note, that although all of the organizations received provincial government funds, for two organizations this was their only source of income.

**Table 7 Sources of Revenue Reported by Number of Organizations**

| Sources of Revenue | Number and % of Organizations |
|---|---|
| Provincial government funds | 14 (100.0%) |
| Federal government funds | 2 (14.3%) |
| Municipal government funds | 1 (7.2%) |
| United Way funds | 3 (21.4%) |
| Foundation Grants | 4 (28.5%) |
| Lotteries | 2 (14.3%) |
| Fees for Good and Services | 6 (42.8%) |
| Fund raising | 5 (35.7%) |
| Donations | 8 (57.1%) |
| Donations in kind | 1 (7.2%) |
| Volunteers | 1 (7.2%) |
| Memberships | 6 (42.8%) |
| Interest on investments | 7 (50.0%) |
| GST rebate | 3 (21.4%) |
| Other | 8 (57.1%) |

Surprisingly, Table 8 demonstrates that no relationship exists between the number of reported revenue sources and the size of budget, illustrating that all the revenue sources did not contribute equally.

**Table 8 Budget Size by Average Number of Revenue Sources**

| Budget Size | Average Number of Revenue Sources |
|---|---|
| $500,000 + | 4 |
| $400,000 to 499,999 | 5 |
| $300,000 to 399,999 | 8.5 |
| $200,000 to 299,999 | 4.7 |
| $0 to 199,999 | 2.5 |

Finally, Table 9 examines the distribution of revenue sources for all organizations and explains why there was no relationship between the number of revenues sources and size of budget. By far, the majority of the organizations' revenue originated from the provincial government. Of the $4.7 million reported as revenue by the 14 organizations, 3.9 million or 84.5% originated from the provincial government while, the remaining $0.8 million (15.5%) was distributed among the 14 other sources.

**Table 9 The Distribution of Revenue by Source**

| Revenue Source | Amount | % of total |
|---|---|---|
| Provincial government funds | $3,982,743 | 84.50% |
| Federal government funds | $14,001 | 0.30% |
| Municipal government funds | $2,500 | 0.10% |
| United Way funds | $258,277 | 5.50% |
| Foundation Grants | $30,791 | 0.70% |
| Lotteries | $6,420 | 0.10% |
| Fee for Service | $166,911 | 3.50% |
| Fund Raising | $70,909 | 1.50% |
| Donations | $65,084 | 1.40% |
| Donations in Kind | $47,860 | 1.00% |
| Volunteer Services | $28,820 | 0.60% |
| Memberships | $2,001 | 0.00% |
| Interest | $12,626 | 0.30% |
| GST Rebate | $6,342 | 0.10% |
| Other | $16,375 | 0.30% |
| **Total reported revenue** | **$4,711,660** | **100.00%** |

Rekart's (1993) research in British Columbia involved nonprofit organizations providing a variety of human and social services. In contrast, our sample included only those providing mental health service. However, making a comparison proved to be useful as demonstrated in Table 10.

**Table 10 A Comparison of the Distribution of Revenue Sources**

| Revenue Source | Rekart (1982) | Rekart (1989) | Evenson (1997) |
|---|---|---|---|
| Provincial Government | 74.2% | 73.6% | 84.5% |
| Federal government | 3.7% | 4.8% | 0.3% |
| Municipal | 1.0% | 0 .8% | 0.1% |
| United Way | 2.2% | 1.7% | 5.5% |
| Fund raising, Memberships, Donations | 5.2% | 6.3% | 4.5 % |
| Fee for Service, other | 13.7% | 12.8% | 5.1 % |
| Total | 100% | 100% | 100% |

The comparison confirmed that the provincial government continues to be the single largest contributor of revenue, by far, well exceeding the total of all other sources. The difference in federal and municipal government contributions may be attributed to a broader range of services that were included in the B.C. research. The traditional nonprofit revenue sources such as fund raising, memberships and donation continued to account for approximately 5% of the revenue. Finally, the fee for service option appears to be more developed in British Columbia.

**Provincial Government Funds**

All of the organizations interviewed, agreed that they benefitted substantially from entering into a funding agreement with the Manitoba government. They acknowledged that they would have been unable to generate the same level of funding from any other single source or multiple sources. In addition, it was recognized that without provincial

government funding they would not be able to provide the level or range of services they were delivering.

Table 11 examined the portion of organization's budget that came from the provincial government. This substantiated the executive directors' claims regarding the extent of their dependence on provincial government funding. Nine organizations reported that more than 70% of their budget originated from the provincial government. None of the organizations reported that provincial government funding accounted for less than 50% of their budget. More recent Manitoba research revealed similar results that except for religious services, the provincial government was the single largest source (60%) of funding for the sampled organizations in all categories (Brown, Troutt & Boame, 1999).

**Table 11 Portion of Budget from Provincial Government**

| Percent of Total Budget | Number and percentage of organizations |
|---|---|
| 100% | 2 (14.3%) |
| 90% - 99% | 4 (28.5%) |
| 80% - 89% | 3 (21.4%) |
| 70% - 79% | 2 (14.3%) |
| 60 %- 69% | 3 (21.4%) |
| 1 % - 59% | 0 |

**Federal and Municipal Governments Funds**

In addition to provincial government funding, 21% of the organizations received funds either from the federal and municipal governments, with one organization receiving funding from all three levels of government. Funds from federal and municipal government sources were not ongoing but designated for short term initiatives. Their contributions to mental health organizations' budgets ranged from 0.6% to 8%. Traditionally, health services have been a provincial government responsibility, reducing the likelihood of other forms of government funding such services.

**United Way**

United Way funding was ongoing and designated to the provision of a specific community service, resulting in a stable funding source similar to provincial government funding. Of the three organizations receiving funding from the United Way, two received both urban and rural United Way funds. In both cases, these organizations were located in smaller urban centers servicing a large rural area.

United Way contributions ranged from 1.5% to 15% of an organization's budget, with an average 5.5%. They ranked the second largest revenue source for mental health nonprofit organizations.

**Donations, Donations in Kind and Volunteer Services**

Reporting inconsistencies makes generalization difficult. Some organizations lumped monetary donations, "in kind" donations and volunteers services together, while others reported these categories separately.

Regardless, the provincial government funding arrangements had an impact on this revenue source. Self help organizations were required by their provincial government funding arrangements to raise 25% of their provincial-funded services by other means, (10% from fund raising or donations, 15% from donations "in kind"). To achieve this objective, several organizations assigned a monetary value to volunteers hours and included their value as a source of revenue.

Donations are traditionally considered a major income source for nonprofit organizations. In fact, in terms of the total amount Canadians donated to charities, health organizations were the second largest beneficiary, receiving $773 million, or 17% of the total amount of donations (Hall et al, 1998). Yet, only eight of the organizations reported this category as a source of revenue. More importantly, donations accounted for an average of 3% of an organization's revenue. This may be related to the stigma associated with having a mental health problem. Definitely, this revenue source was not sufficient to support the level of service delivery desired by organizations.

**Fund Raising**

Contrary to common belief, not all the nonprofit organizations were involved in fund raising. Only 42.8% of the organizations reported this activity as revenue source. Self help organizations demonstrated a preference for fund raising in response to their funding arrangements, which required them to generate revenue from other sources. Two organizations had never participated in any form of fund raising. Several others had stopped fund raising activities deeming them to be too time consuming and detracting from service provision as illustrated by these comments;

> The fact that we had to do all this fund raising really has taken away from the major service we provide.
>
> When you have a small staff you can't spend 50% of your time doing fund-raising.
>
> Sometimes you spend staff time doing fund raising in order to cover the salaries of the staff doing fund raising.

These results are consistent with other research which identified organizations' concern that the amount of staff and volunteer time required for fund raising was often excessive without any guarantee of substantial results (Rekart, 1993). Choosing fund raising activities consistent with the organization and membership's values also proved to be a challenge. In one organization, the membership voted not to be involved in fund raising activities that included any form of gambling or the sale of alcoholic beverages in recognition of the impact both activities had on consumers of their services.

Fund raising mental health organizations indicated competition for funds had increased and required more sophisticated approaches. Although, none had hired

professional fund raisers or telemarketers, some organizations recruited board member for their fund-raising skills.

> You have to know how to do it and have people who like doing it.
>
> One of our strengths has been,(we have been) very successful recruiting board members who are very good at it, it's their passion

Organizations demonstrated varying success with fund raising. The percentage of the revenue accounted for by fund raising varied from 1.5 % to 20.4 %, with average of 1.5%.

**Lottery Funds**

Lottery funds are dispersed by Manitoba Community Services Council for short term special projects. The mental health community was ambivalent about accepting lottery funds because of its concern about the negative impact which gambling had on their consumers. Two organizations received lottery funds amounting on average to less than 0.5% of their revenue.

**Foundations**

Foundations were considered excellent sources of funds for short term projects or capital purchases. However, they did not provide ongoing funding for service provision. The most common sources of foundation grants were The Winnipeg and Thomas Sill Foundations. Their contribution varied from $4,067 to $10,000 and on average accounted for 0.7% of the organization's revenue.

Executive directors believed that their association with the provincial government increased their credibility, and consequently, their ability to acquire a foundation grant. Conversely, they felt there were more organizations competing for grants. This observation was confirmed. In 1996, The Winnipeg Foundation reported a 30% increase in applications for funding and subsequently, had to hire additional staff to process the applications (Annual Report, 1996).

Preparing a proposal for foundation funding requires a specific set of skills that not all organization possess. In response, one organization contracted out proposal writing on a commission basis. Others recruited board members specifically for their ability to prepare proposals.

**Fee for Service**

Fees for Service are also referred to as the sale of goods and services, program and service fees. There is speculation that nonprofit organizations become involved in forprofit activities for a variety of reasons. Wiesbrod (1990) argued that reduction in government support was forcing organization to seek other sources. On the other hand, the cross-subsidization model advanced by Liftset (1989) speculates that organizations use the revenue to subsidize other insufficiently funded activities.

In Manitoba, executive directors indicated that they were involved in the sale of goods and services by mental health organizations for two reasons: first, to generate

income and reduce their dependence on the provincial government and second, to provide employment opportunities for their clients. The activities they were involved in reflected these purposes. The income generated from the sale of educational materials, vocational testing, counseling services, and workshops was used to subsidize non-funded services. Sale of services such as moving, yard work, cleaning, assembly work, and sale of recycled building products provided employment opportunities for mental health consumers .

Five organizations were involved in forprofit activities generating a range of income from $2,158 to over $67,000. For two organizations, the sale of goods and services contributed more than 20% of their budgets, for a third over 10%. One business, owned and operated by a mental health organization, was self sustaining, providing full and part time employment for several staff.

On average, mental health organizations in Manitoba generated more income from forprofit activity (3.5%) than from traditional nonprofit activities such as collecting donations (1.4 %), selling memberships (0.0%) or even fund raising (1.5%). Forprofit activity ranked third as a source of revenue. This signifies a major shift for nonprofit organizations. Indications were that more organizations were exploring this option. One organization was in the process of purchasing a building in order to generate income from renting out space. Another was investigating the sale of counseling service to an employee assistance program for a private employer.

Engaging in forprofit activities had major tax implication for one of the nonprofit organizations. Businesses that sell goods and services are required to collect Good and Services Tax (GST) on behalf of the federal government. A Revenue Canada audit of the organization claimed that insufficient tax had been collected and required the organization to repay over $10,000 nearly eliminating their reserves.

**Interest on Investments**

When organizations accumulate excess funds, it is common practice to deposit these in various guaranteed investment or saving certificates as a means of generating revenue.

Low interest rates, income tax implication and rumors of a "claw back" of surplus funds, have reduced the number of organizations participating in this activity. Therefore, only half of the organizations reported interest as revenue. In all situations, it accounted for 0.1 % or less of their total revenue.

**Membership Fees**

Even though all of the community-based nonprofit organizations are required to demonstrate community involvement (which is often accomplished by citing the size of the membership), only three reported the sale of membership fees as a revenue source. They accounted for less than 0.5 % of their revenue in every situation. Mental health

organizations work with the most marginalized members of the community. As such, membership fees were kept to a minimum to ensure participation and accessability.

In review, an analysis of nonprofit organizations' sources of revenue revealed that they are not able to generate enough income to sustain a significant level of service provision without major provincial government support. On average, organizations reported 5 different sources of revenue of which four generated 15.5% of their income while one source, the provincial government, provided 84.5%. Surprisingly, forprofit activity contributed more income than the traditional nonprofit income generating activities. This marks a significant shift in nonprofit revenue generating activity. Obviously, organizations benefitted substantially from entering into funding arrangements with provincial governments, but there were budgetary problems associated with the funding arrangements.

**Budget Issues Related to Provincial Funding Arrangements**

Unanticipated costs were the most commonly reported problem associated with provincial government funding arrangements. Often, increased employer contributions to Unemployment Insurance, and the Canada Pension Plan were not anticipated nor compensated for by the provincial government. Many of the organizations were either providing new services or in new locations making it difficult to estimate levels of demand and subsequent staffing needs.

> There were under estimated costs that did not have much to do with government, it has to do with the original planning developed even before I was hired and so there were a lot of areas - especially in staffing levels that were under budget.
>
> We didn't have a building so we didn't know how much taxes, would be, utilities, and other costs. You actually don't know what some of the costs would be till you have been running for a year.

Rural organizations, in particular, experienced difficulties estimating the cost for expenses necessary for providing services to large geographic areas.

> Telephone and travel have been a thorn in our sides from the beginning because in order to provide service in these areas, you really need to have the money to do both.

Finally, two mental health organizations incurred legal costs as a result of unionization. Inexperienced with the unionization process, the organizations hired lawyers as consultants to assist them with negotiations. Unionization in both cases resulted in modest increases in salary and/or benefit packages.

Lack of access to lines of credit and inflexible budgets were also mentioned as contributing to the difficulty of managing budgets. Unlike businesses, organizations with provincial government funding arrangements don't have access to lines of credit, nor were they allowed simply to transfer funds from one budget line item to another in response to unanticipated costs. (Funding arrangements restricted the transfer of funds between two categories: salaries and operations unless permission was received to do so from provincial governments officials.)

Approximately a third of the organizations experienced cash flow problems related to cash reserves. Professional organizations were required to maintain a reserve equivalent to one month's budget. Ironically, they were likely to experience late payments from Treasury Board. Self help organizations, on the other hand, were not required to maintain reserves and were less likely to experience late payments. This could be attributed to the fact that self help organizations tended to be more reliant on government funding than the professional organizations.

Provincial government regulations regarding handling of deficits and surplus also contributed negatively to prudent fiscal management. Deficits were clearly the responsibility of the organization. The opposite was expected if an organization was able to acquire a surplus, as illustrated by these comments;

> You are required to live within your means ... If deficits were incurred you are answerable to the board .. .. If you incur a deficit you know they [government] are not going to give you any more money to deal with the deficit so it going to be your responsibility.
>
> If the surplus was too large, we were informed it would be returned to government. We were told surplus funds were not ours and we required permission to spend them.

Under funding of salaries was consistently mentioned as a budgetary problem as typified by these comments:

> The grant given to us by provincial government doesn't cover the salaries of staff... we are fund raising like crazy to do so.
>
> It's a double edge sword - You do get an opportunity to provide the services but you do not necessarily get the amount for staffing you need to provide the quality of services you want to. What do you do, how do you reconcile this?

Salaries constituted the largest single budgetary item for nonprofit organizations. Under funding in this category has major implications for an organization's ability to deliver service. This will be discussed in more detail later in the thesis.

Stagnant funding was just beginning to be a concern. A few organizations were anxious that the provincial government would not increase their funding levels to compensate for inflationary costs. This has proven to be true. Recently, the Manitoba Mental Health Advisory Council (1999), which represents organization receiving provincial government funding, reported that none of their organizations had received an increase in funding since the initial funding arrangements were awarded. For some organizations this amounts to eight years of no increases in their largest revenue source. Furthermore, several organizations received a 1 to 2% decrease in 1998. With an inflation rate averaging 1 to 2% per year, this would be equivalent to approximately a 10% to 15% reduction.

This level of reduction should compromise an organization's ability to sustain services. In the forprofit world, the response would be to cut their losses by reducing the level of service provided - as demonstrated by the banking industry. Instead, the nonprofit organizations have continued to deliver the same level of service and fulfill their commitment to the community. None of the organizations reduced their overall level of service. This may provide an explanation why the provincial government chose not to tender funding arrangements annually. Cost containment can be achieved without

tendering by simply allowing inflation to take its course. Plus, they do not incur the cost of re-tendering or create major service disruptions.

As demonstrated earlier, there was evidence that organizations were adopting business-like approaches as a means of supporting their nonprofit activity and reducing their reliance on government. Quoting an executive director:

> As nonprofit, we tend not run as business but rather as, you know as warm fuzzy organizations. Then when, we run into problems doing wonderful work. We end up running deficits..... It is important to talk money and begin functioning as viable organizations.
>
> So what we needed is more partnerships and alterative forms of funding are necessity rather than a little extra. We have gone through a phase where we were very government dependent to extent that without the government we probably wouldn't exist. Now, the board is moving towards trying to make a better balance of funding so our services are not so dependent on government funding. We are going in a real estate option. We're going to seek revenue?

This shift has major implications for the nonprofit sector. It may bring it into conflict with the business sector which believes nonprofit organizations have been given an unfair advantage because they are subsidized by government funding. It may impact their tax exemption, if their forprofit activities exceed all other sources of revenue.

In summary, the influx of provincial government funds into the nonprofit mental health sector was welcomed because it enabled organizations to provide services not previously available. Even though a variety of budgetary problems were associated with the funding arrangements including unanticipated costs, inflexible budget lines, cash flow problems and under funding. Recently, decreasing funding levels have emerged as an

issue. In response, organizations have begun to explore forprofit activities as a means of subsidizing services. If this trend continues, it will result in a fundamental change in the functioning of nonprofit organizations.

## Dilution of Advocacy Role

### Systemic Advocacy

In contrast with the image of nonprofit organizations acting as mediators between the community and government institutions, only one mental health organization identified systemic advocacy as its primary organizational objective. In their own words:

> We see ourselves as primarily an advocacy organization whose focus is to create change at various levels. We were reluctant participants of the expansion - with no intention of becoming a mega service provider.

In this case, service provision was viewed as secondary activity - as a means of demonstrating an alternative service model to government.

> There need to be something different and we wanted to demonstrate alternative models. When we were asked to expand, we thought long and hard....it was a controversial issue at the board level. However, if you don't deliver service.... you have to look at your ability to influence because you don't have the practical experience (of delivering services).

The depth of involvement was evident in their annual report which detailed their involvement in fourteen "coalitions, committees, networks and community groups" consisting of: Manitoba Medicare Alert Coalition, Consumer Advisory Committee, Working Group for the Coordination of Mental Health Services in Winnipeg, Community Coalition on Mental Health, The Winnipeg Regional Mental Health Council, Manitoba

Supported Employment Network, Community Housing and Support Enrichment, Manitoba Housing /Mental Health Services Working Group, Faculty of Social Work, Field Instructions Advisory Committee, Case Management Advisory Committee, and the Workplace and Wellness Committee .

When the research was being conducted, this mental health organization was reconsidering whether to remain a large service provider acknowledging:

> that to continue doing so has an impact on our ability, energy and resources to initiate the kind of change.... Expansion of services has meant a lot of time and energy is expended managing the organization, developing policy and procedures, managing human resource, budget administration and is taken away from advocacy and public education.

Some preliminary discussions occurred concerning the possibility of "spinning off the service" and creating an organization whose sole purpose was service provision thereby, freeing the organization to concentrate on systemic advocacy. Subsequently, they have decided to continue to provide service and advocate for system change.

Even though they did not identify systematic advocacy as a primary objective, over three quarters (78.5%) of the nonprofit organizations interviewed were involved in systemic advocacy activities:

> My primary job is not to go on committees but to run this place but again, they do inform a great deal of the work.
>
> We do a lot of advocacy. I sat on 29 committees since 1991-1992 . We don't advertise our advocacy role. Although we do it a lot of the time. It is not our primary role. Self help is.

All the respondents were adamant that their ability to speak out or raise issues had not been compromised by entering into a funding arrangement with the provincial government, as these comments illustrate:

> Have we kept our mouth shut now that we are getting money? We wouldn't meet with senior bureaucrats if that were the case.
>
> There is not been any towing the line because we are funded.... our advocacy role has not changed... it's consistent with how we have conducted ourselves.
>
> We are still there raising issues.. I don't feel confined or restricted. Generally, there is nothing I haven't said today that I have not said to their face.
>
> "I feel obligated..[to the community] ... if we have a contract and we signed that contract. We can't turn around and start doing things that are not in that contract. We don't feel any hesitation in saying that contract in this particular area in wrong. We'll say- this not good. This is not working out. It's a waste of money and time. We wouldn't be afraid to do that.

In fact, the opposite was true. Nearly, three quarters (71.4%) of the organizations described their relationship with the Manitoba government as cooperative, using words like "a partnership" and "a marriage". They believed entering into a funded agreement with provincial government had strengthened their ability to influence:

> We are not intimated by government, in fact it's enhanced the opportunities for advocacy.
>
> By demonstrating that we could effectively deliver innovative services, our credibility has increased.

While none of the organizations chose to describe their relationship as confrontational, their relationship between government was not trouble free. Quiet

diplomacy rather than a public display of disagreement was the strategy of choice, as demonstrated by these comments:

> We don't believe in embarrassing any government. We developed a win-win situation. We inform government of problems or difficulties. If there is no resolution, only then are those details made public.
>
> We believe in working within the structure and the system.

This was not always the case. Here was how one executive director described his relationship with government prior to the implementation of the reform:

> It has changed for me. I was involved in the reform process from the start... I went to the paper, confronted people, stirred up a lot of news, made some enemies, but it was necessary to get the reform going by belonging to committees that worked on the formulation of those basic (reform) documents.
>
> Prior to the reform, when we were trying to initiate change, there was much more confrontational tactics trying to raise the profile of mental health. But once the province made a commitment to the reform process, it's become more cooperative and consultative than confrontational.

Clearly, the executive directors believed that their work in the community had influenced the government's decision to implement the reform of mental health services. Plus, they believed that the primary reason they received provincial government funding was due to their organization's goals and values being consistent with the principles and objectives detailed in the Manitoba Health Reform documents. As one executive director stated:

> I am accountable to my board and their vision. I represent them. They are my employer. It just happens. Our visions coincide at this time.

This is a belief supported by the fact that the majority (78.5%) of the organizations were involved in the consultation process during the reform of mental health services and subsequently all were awarded a funding arrangement with the provincial government. Therefore, it was not surprising, that organizations believed that their ability to advocate was not curtailed by their acceptance of provincial government funding arrangements.

**Recent Developments**

While the research was being conducted, rural health services began to be "regionalized" by the provincial government. Some of the provincial funding arrangements were transferred to their respective regional health authorities. Several interviewees speculated this process would make the government inaccessible for advocacy purposes and requires a shift in strategies:

> From 1992 until now, the government had a separate Deputy Minister of Mental Health. Organizations had a specific person to go to lobby for change. Now that the mental health services have been subsumed under Health. Although, a more holistic approach... your target for change becomes a little more nebulous. In addition, with the Regional Health Authorities, government becomes more removed. There needs to be a mechanism for concerns and issue regarding mental health services to be addressed provincially rather than within each regional authority. Hopefully, the provincial advisory committee will remain in place.

One rural organization identified the implication of this shift of responsibility and its impact on their relationship with the provincial government and community:

> We are no longer going to be a quiet partner moving behind the scenes but rather have a more a public role. Now that the organization has been given responsibility to deliver the service. It's you who is going to take the rap if there are problems.

> Concern was we were going to look bad. This was not how we wanted to be perceived ... so we went public.

Further research will be required to confirm this trend.

**Individual Advocacy**

Similar to the systemic advocacy role, few mental health organizations considered individual advocacy as a primary organizational activity. Only three (21.4%) of the organizations provided individual advocacy services. Executive directors cited limited resources as the major factor restricting their ability to advocate for individuals clients. Others felt that it was not their responsibility to advocate on behalf of their clients.

One well-established organization, with extensive experience with individual advocacy had noticed a significant drop in the demand for their services. They interpreted this as a result of the increased number of service providers available due to the expansion of the community-based service system. Besides a reduction in demand, they had noticed a shift from complaints about hospital services to those concerning community-based service providers paralleling the transfer of services.

The stigma of mental illness continues to be the most consistently cited factor impacting the level of individual advocacy. Both urban and rural communities experienced difficulties with generic service providers denying services to people with mental health problems.

Surprisingly, the introduction of voice mail was also mentioned as a factor that impacted an organization's ability to advocate on behalf of their clients: "People can't get hold of anybody, anytime, any more."

In short, the majority of mental health organizations believed that their ability to advocate at a system and individual level was enhanced by entering into a provincial government funding arrangement. Funding arrangements increased their accessability and credibility with government officials, while deceasing the necessity for individual advocacy without restricting a mental health organization's ability to advocate. Recently, concerns were expressed that these gains were being eroded with the implementation of regionalized health services which altered the relationship between the nonprofit sector and the provincial government.

**Distortion of Organizational Goals**

Determining whether organizational goals had been distorted proved to be very difficult. Exploring the congruence between an organization's stated goals and their activities produced inconclusive results. Most of mental health organizational's goal and mission statements were very general as represented by the following:

> People with mental health problems participate as citizens within a responsive society
>
> We strive to enable individuals, groups and communities to increase control and to enhance their mental health.
>
> To assist people to live active and independent lives

> The purpose of... is to provide unemployed, psychiatrically disabled individuals with pre-vocational work adjustments and employment services which allow maximum achievement of vocational, economic and social independence.
>
> A program is designed to facilitate the acquisition of skills and supports needed and wanted by members to function in the community they value in the environments of living, learning, working and socializing.
>
> ....is to provide the educational support necessary for sufferers to overcome the debilitating effects of the disorder.

These goal statements allowed for various interpretations and "operationalization". For example, the following goal statement represents a housing program:

> To assist the individuals with chronic and persistent disorders to obtain safe, affordable housing in the geographic locations of their choice.

The goal statement does not restrict or define how this goal was achieved. The organization could choose from a range of possibilities including assisting people to purchase their own housing, lobbing the provincial government to gain access to subsidized housing or locating housing in the community. All of these services would still be consistent with the stated goal of the organization.

Pfeiffer and Salancik (1978) theorize that nonprofit organizations intentionally choose broad goal statements that are flexible so they can respond quickly to shifts in government priorities. On the other hand, nonprofit organizations would indicate their choice of general goal statements enables them to be responsive to community needs.

Regardless, all the mental health organizations were confident that they had not been diverted from their original course as the following responses demonstrate:

> There has been no compromise of our mission or values by receiving funding from the government.
>
> Initiatives are a result of ideas from staff, community, or board not in response to government offering monies.... We are an agent of change.
> New initiatives are driven by membership. The mandate of organizations is to service its members. Any member of the organization can submit an idea that must be explored by the steering committee.

The discussion regarding goals distortion seems pointless. As the budget analysis demonstrated without provincial government assistance, none of the mental health organizations could have provided their existing range and volume of services.

One mental health organization provides an excellent example of the provincial government's financial impact on an organization's ability to provide service. Prior to entering into an agreement with the provincial government, one rural organization's annual budget fluctuated between $5,000 and $10,000. With such a small budget it was only capable of providing the occasional public education event. After entering into a funding arrangement with the government, the organization was granted over $500,000, enabling it to provide supported housing, crisis stabilization, and self help services. Emphatically, the executive director stated:

> We wouldn't have and couldn't have expanded services!
>
> Services would have been difficult to sustain if not hopeless at this level. Utterly hopeless! [without government support].

In review, it could be argued that by selecting (rather than tendering) nonprofit mental health organizations whose visions were congruent with their own, the provincial government reduced the likelihood of diverting organizations from their stated goals, while enhancing their ability to achieve their goals. Goal diversion was not a concern of the organizations interviewed.

**Reduced Client Accessibility**

In Manitoba people requiring mental health services from mental health organizations accessed services in two ways, either by being referred by a professional and/or government staff or by requesting service on their own behalf - (i.e., self referral). The research revealed that 50% of the mental health organizations accepted a self referral for all their services provided and 14.3 % of the organizations could only be accessed by being referred by a Community Mental Health Worker (provincial government staff). The remaining 35.7% used both methods depending upon the type of service.

The choice of intake process corresponded with the type of organization and the service provided rather than the type of government funding arrangement. The bulk (80%) of the self help organizations relied on the self referral method. Even though they were diagnosis specific, they did not require verification of diagnosis or an assessment of suitability, whereas, the majority (83%) of organizations providing "professional" services required a referral.

Contrary to the predication that provincial government funding would be tied to stricter admissions requirements, there appeared to be no evidence of this. Nearly all the organizations (92.8%) stated that their services were more accessible as a result of their funding arrangements. The government funds enabled them to hire more staff and increase the number of people served without imposing any new restrictions on their referral process. The arrangements requiring a referral from a provincial government staff person predated the new funding arrangements. In fact, there appeared to be a reduction in the monitoring for this purpose. Several organizations mentioned that prior to the reform, government employees were members of their intake committee that reviewed applicants. Recently they had withdrawn simply stating "we trust you".

Since the initial funding arrangements were negotiated, several organizations changed their intake/admission procedures in response to various factors. A decrease in government funding forced one organization to tighten their screening process:

> We haven't been told who we have to serve but because we don't have the level of funding requested initially. We had to cut staff at certain times [evening]... thereby, we introduced tighter controls regarding who we admit to ensure staff safety.

A high level demand for their service compelled another to discontinue accepting "drop-in clients". People were asked to make an appointment prior to coming to the office as a means of ensuring staff would be available to respond to their needs.

Finally, the decision by government to close hospital beds and shift to community-based services has meant a transfer of people traditionally treated in a hospital into the community. Community-based organizations have noticed a change in the people they serve:

> People are discharged from hospital sooner and are more actively psychotic We noticed higher levels of chronicity. We serve a range of people, but we have noticed more people with problems functioning.
>
> We are definitely working with people with more complex problems - increased levels of poverty, lack of adequate housing, and employment opportunities - the determinants of health.
>
> Because clients are not getting into a hospital as quickly or at all, we are getting more of those folks.
>
> Most people when they get admitted to a hospital are more acutely ill.
>
> The likelihood of our clients having concurrent disorders - substance abuse and mental health problems - has increased.

This change in client population and level of demand has challenged some organizations' capacity to respond. Based on a program review, one organization decided to tighten the intake screening process:

> Needs maybe too high for our organization to handle. Doctors have become more aware of the service. We are receiving more referrals ... concerns have arisen that some of the people being referred to the program maybe too high for the organization to handle as result we have had to look at safety concerns and pulled back in a few areas.... We have learned what we can do and what we can't do.

Another restricted their intake criteria to individuals within a narrower age group eliminating older clientele:

> Long term institutionalized people have lost hope are not looking to make changes whereas younger people are less likely to have lived in institutions or want to make

> changes.....We want to ensure that we work with the most in need but also with the ones who are most successful. What is the point of setting people up to fail.

Finally, a code of conduct was introduced by one organization as means of eliminating disruptive clients:

> We want to provide a safe and positive environment. We are not allowed to restrict membership but we want a positive safe environment for our members. It is important for people's recovery. This decision was made by the membership.

Although the provincial government had chosen not to interfere by specifying the admission criteria, this demonstrates how other provincial government decisions have impacted accessability. The increased number of community clients without an increase in funding has forced organizations to be more selective in the people they serve. This has created a new role for the community-based organizations: gate keeper.

To summarize, the overall accessability to services was enhanced by the provincial government's funding arrangements without being accompanied by requirements for tighter intake criteria. Subsequently, organizations have chosen to screen intake in response to changes in the client population related to the shift to a community-based service system.

## Staffing Implications

### The Use of Volunteers

Surprisingly, for nearly half of mental health organizations, board members constituted the only volunteer component of their organization. Just over half (57.1%) of the mental health organizations use volunteers for non-board activities such as service delivery. The number of volunteers used by the nonprofit organizations ranged from 10 to 15. This is significantly lower than the average 98 reported by other Manitoba nonprofit organizations in the health field (Brown, Troutte & Boame, 1999). Organizations reported very little change in the use of volunteers as a result of their funding arrangement.

The use of volunteers varied with the type of mental health organization. All the self-help organizations used volunteers. Providing volunteer opportunities for consumers of mental health service was congruent with their philosophy that "peoples with mental illness need to be given meaningful work to do". On the other hand, only a third of the professional organizations used volunteers. Government funding arrangements encouraged self-help organizations to use volunteers by requiring them to raise 10% of their budgets from donations and 15% as "services in kind". There was however, no indication that the numbers of volunteers were increased to meet this requirement. Often, these same organizations had relied on volunteers prior to their new funding arrangement with the provincial government, as confirmed by this statement:

> Prior to 1992, we were functioning on a prayer and a song.. existing on the brute force of our volunteers

Both self help and professional mental health organizations suggested that several factors discouraged the use of volunteers:

> A large number of volunteers require a lot of time and money and we don't have either.
>
> We have endless volunteers in Interlake, but we are flat broke. I have lots of money and some volunteers in Westman and I have lots of money and lots of volunteers in Winnipeg, no money and few volunteers in Northman.
>
> It's difficult getting volunteers with the skills required and someone who is reliable.
>
> Once people found out the volunteer placements were with us, they backed out.

These factors may provide an explanation why organizations continued to work with small numbers of volunteers even though some were encouraged to use volunteers by government funding arrangements.

**The Use of "Professional" Staff**

Mental health organizations' staffing ranged from 2 to 25 staff members with a average of 12. The average for full-time staff members was 5.8, while part-time staff was slightly lower at 5.3. Only three organizations reported the use of casual staff with an average of 7.6.

When self help organizations and professional organizations were compared, a different picture emerged. Self-help groups were four times more likely to employ part-time staff than professional organizations.

**Table 12 Type of Organization by Type of Staff Position**

| Organizational Type | Full-time | Part-time | Casual |
|---|---|---|---|
| Self Help | 14.3% (9) | 76.6% (49) | 9.4% (6) |
| Professional | 64.4% (67) | 19.2% (20) | 16.3% (17) |

N=self help = 64, professional =104

The difference in the hiring pattern was attributed to funding levels and organizational values. Three self help groups were funded to deliver province-wide services. These organizations chose to hire part time staff dispersed throughout the province rather than have full time staff centrally located.

Table 13 illustrates the impact of the increase in provincial government funding had on the organizations' ability to hire staff. Conclusively, provincial government funding arrangements had a significant impact on the number of paid staff. By 1997, 109 new staff members were hired as a result of the new funding arrangements. Prior to the reform, 78.5% of the organizations had less than 10 staff members. After the reform, this had shift to only 42.9% of the organizations

**Table 13 A Comparison of the Number of Staff Before and After the Reform**

| Number of Staff | Before Reform | After Reform |
|---|---|---|
| 21-25 | 0 | 1 (7.2%) |
| 16-20 | 1 (7.2%) | 2 (14.3%) |
| 11-15 staff | 2 (14.3%) | 5 (35.7%) |
| 6-10 staff | 2 (14.3%) | 2 (14.3%) |
| 0-5 staff | 9 (64.2%) | 4 (28.6%) |

Over the five year period investigated, 78.6% of the organizations reported a net gain in the number of staff, 7.2% reported a decrease, while 14.3% remained constant. Of the 109 new jobs reported, 34% were full-time positions, 44% part time positions and 22% casual positions. All of the mental health organizations attributed their staff increase to their government funding arrangement. They were adamant that they would have been unable to generate sufficient income from other sources to hire the new staff.

Only one organization reported a decreased number of employees, which resulted from a change in the service model rather than due to the funding arrangement.

Since the initial expansion, two other organizations reduced the number of staff members (while maintaining a net gain in staff overall). The reductions were attributed to the accumulative impact of decreased funding for a one year period and static funding for the remaining four years. The executive director described the situation:

> The organization had to determine how we were to continue to provide the service. We are not getting any increments, we are committed to giving increments, we are fortunate that we built in a generous budget - there was slippage in the budget. We took that money and applied to the staff salaries, but that wasn't enough.... resulting in a layoff.

In spite of the reduction in staff, the level of service remained the same. Organizations did not renegotiate their initial funding arrangements but continued to assume responsibility for delivering the same level of service despite a reduction in staff.

**Staff Salaries and Benefits**

Traditionally, 80% of the cost of delivering human and social services is consumed by salaries and benefits. Provincial governments attempting to contain the cost of service delivery have been frustrated by strongly unionized government employees. It was believed that much of the impetuous for the government's move to non-unionized nonprofit organizations was associated with the governments inability to contain these costs.

Clearly in this situation, staff salaries and benefits were not significantly improved with the influx of government funds. Over two-thirds (67.8%) of the staff were paid hourly wages and received no benefits other than those guaranteed by minimal labour standards. Executive directors attributed the poor salary levels and lack of benefits directly to the provincial government funding arrangements. When organizations negotiated the original proposals with government officials, particular rates of pay and

salary levels were strongly recommended by government officials as illustrate by these comments:

"They told you what you get - fixed forever."

"We were told what we could pay our staff."

Concerned that the low salary levels would affect their ability to retain staff, several organizations requested and received permission by government officials to increase their staff salaries but without any additional funding.

Although, there was a commonly held belief that professional staff working in the community was paid significantly less than those employed by the government or institutions, the researcher was unable to produce comparable job descriptions to facilitate this analysis.

In an attempt to improve their working conditions, staff of three organizations unionized. Two occurred after the initial expansion. Unionization had a minimum impact on salaries, resulting in modest salary gains for staff represented by the Manitoba Union of Nurses and the Canadian Union Public Employees.

An unanticipated factor impacted salary and benefits. The "pre-existing condition clause" included in most long term insurance packages meant that staff, who had disclosed a pre-existing psychiatric condition, were excluded from receiving disability benefits.

Self- help organizations who hired consumers experienced difficultly obtaining benefits for their staff.

**Staff Qualifications**

From executive directors' descriptions of their staff's qualifications, it was clear that mental health organizations valued consumer experience over professional experience. This can partially be accredited to the provincial government policies. One objective of the reform was the inclusion of consumers in every aspect of the mental health system, including service delivery (Manitoba Health, 1993). As such, all organizations were encouraged (although not required) to develop plans for inclusion of consumers as staff members. Self-help organizations were more apt to hire consumers than other mental health organizations. This was expected based on their service delivery model. Executive directors of self-help organizations were quick to point out their staff were as skilled or as qualified as those employed by other mental health organizations.

Surprisingly, only half of the professional organizations hired staff with post secondary education, or a specific professional designation. The qualifications varied with the type of service. The crisis stabilization units were required by provincial standards to have a nurse on site at all times. The room and broad support program employed occupational therapists. The supported housing and employment programs hired a variety of professionals, although social workers tended to dominate.

Executive directors believed that their ability to hire and keep professional staff was undermined by government funding levels for salaries:

> I think that in a large part that was what was expected [by government] and with the money that there was for wages it would be almost impossible to get professionals...I can't see that ever happening.

Several of the executive directors employing professional staff were concerned that the low level of salary would eventually lead to de-professionalization and an increased use of para professionals as exhibited by these comments:

> I think in the last 3 - 4 years with reform, there has been a trend to turn it around - professionalism - to create generic workers - multi-skilled. I've see that as a concern a stalling of professionization.... I have sensed a shift to use para professionalization

Unable to raise salary levels, mental health organizations explored other ways to compensate professional staff: they reduced work hours while maintaining their salary levels; introduced modified work weeks; created more flexible work hours so staff could attend to personal and family needs; and finally, rewarded staff with opportunities to attend workshops and conferences.

On the whole, nonprofit organizations continued to rely on their ability to attract staff committed to working in the nonprofit sector and who were willing to work harder and for less remuneration than their public sector counterparts:

> I think that says a lot for the people who work here because.. a wage is nice but we really believe in what we are doing ... so we are all pulling in the same direction.

**Staff Training**

Providing mental health services in the community requires a unique set of skills and knowledge. Unfortunately, government funding arrangements provided mental health organizations with few resources for training or professional development:

> We had $1,000 in the budget. We had to cut it to $400 and that's for a staff of 12.... unfortunately, its one of the first areas that gets cut or is used to cover other areas.
>
> We were refused monies to train. We were told that the money was needed to redeploy and retrain institutional staff.
>
> Often there is no time, or no one to cover for you while you're away. Basically, you learn as you go, ask someone who would know rather than go out and take a course.

Faced with the challenges of low salaries, increasing complex needs of clients, executive directors employed a variety of strategies to compensate for the lack of training funds:

> No funds for management training... we try to get advice, and training wherever possible, network with more experienced managers.. use board members.

When funds were available, many complained that the available professional development was inadequate, superficial, and/or inconsistent with the organization's mission or values. Executive directors expressed frustration with the lack of more advanced or focused programs for themselves and their staff.

Along with the lack of resources, distance was also a factor for rural and northern organizations: "The cost to send people to Winnipeg is prohibitive." Rather than send

people for training, organizations exchanged resources or banded together to bring them into the community.

**Staff Evaluations /Performance Appraisals**

Concerned with maintaining their credibility with the community and their funders, all of the organizations reported completing annual staff performance evaluations. Without assistance or direction from the government, mental health organizations developed their own processes and standards. As such, there was a lack of consensus regarding the staff performance appraisal process as revealed by these comments:

> We have become more diligent about performance evaluations. I have developed a whole new performance appraisal process that's moved to a more peer review process.
>
> Our goal is to develop a more comprehensive system with behavioral expectations as result of an organization need for increased accountability of the organization.
>
> It's very difficult to do appraisals of staff that work alone in rural areas, and with no clear standards, or measurements available.

To summarize, government funding arrangements, which initially resulted in substantial gains in the number of paid staff, have not been sustained as their purchasing power has been eroded by inflation. An organization's capacity to hire professional staff, train and evaluate their performance has not been enhanced by government funding arrangements. If the trend for increased demand for service and complexity of clients needs continue, it may compromise an organization's capacity to deliver services.

**Decreases in the Level of Integration of the Service System**

In a community-based service system, cooperation among service providers is essential for an integrated service system. Such a system is evident when organizations reciprocate referrals, coordinate services and jointly deliver programs (Provan & Milward, 1991). All community-based mental health organizations interviewed were involved in some of these activities indicating that the level of cooperation and ultimately, the level of integration had not been impacted negatively by the change in funding arrangements.

As discussed in the accessibility section, 50% of the organizations accepted self referrals, reducing the need for reciprocal referrals. Clients could refer themselves without the intervention of a professional or another service provider. When professional or clinical referrals were required, mental health organizations acknowledged and accepted referrals from other mental health organizations. In their words:

> It is a two-way street - if someone needs our services other organization will refer to us and vice versa. We have become interdependent.

> I don't believe in getting involved in that (competition) because that destroys relationship and doesn't benefit the clients. My goal is to have the best working relationships possible with all service providers, to benefit our guests. I don't like to put down other organizations and I don't allow staff to do so.

When organizations experienced problems with their referrals being accepted by other organizations, generally it involved service providers outside the mental health field:

> They have been reluctant to allow people diagnosed with mental health problems to access their programs (referring to addiction and women's shelters). If there is a good quality service we don't need to duplicate it by developing one specifically for people with mental health problems. This would not be consisted with our values of social integration.

Involvement in joint service coordination was the common practice among the community-based nonprofit organizations. However, this consideration was not always extended to staff of community-based organizations by the hospital or provincial government services. Although, an observation was made that the practice of including community-based staff in service consultation was broadening and could be attributed to the increase in the credibility of community-based nonprofit organizations. As the executive director of a self-help organization observed:

> I think they were reluctant at the beginning to include us, but as we became more established, the relationship has really developed and we are included now.

Finally, all of the mental health organizations were involved in either joint programming and/or networking activities. Excerpts from annual reports provided examples of the activities:

> Teamed up with... to host the first Depression Screening Day ever in Westman. The event was attended by over 80 people and the ground work being laid for a second Annual Depression Screening Day .
>
> Throughout the year, the unit worked hard at developing effective and smooth working relationships with various agencies in the community with women the unit needs to cooperate when providing services to clients.
>
> Protocol development with agencies like Child and Family Services, the RCMP and others has been steadily improving.
>
> Partnering with Healthy Thompson to provided a parenting workshop - How to Talk So Kids Will Listen.
>
> A number of networking initiatives conducted throughout the Interface Region .i.e.. Participated in Mental Health Week activities, Health Fairs, information sessions, regular case consultations with Community Mental Health Workers in Selkirk, consulted with staff of Selkirk Mental Health Center.

In another example, five mental health organizations based in Winnipeg cooperatively designed "a mental health workshop presenting the consumer's perspective on the value of empowering, recovery based mental health services". The workshop was delivered throughout Manitoba, employing a variety of formats ranging from a full day workshop to half day and evening presentations.

The introduction of new and expanded services in the community did not contribute to increased competition as was initially anticipated. Instead, the introduction of new services was considered a positive development rather than a threat. Frustrated with the high level of demand for service and their inability to locate appropriate services for clients, organizations welcomed the new service providers. When asked who their competition was, executive directors' responded:

> I don't know if the competition is the right word, our program is another option to consumers, we don't view this as competition but rather than as an increase in the choices available to consumers of services.
>
> No shortage of demand - therefore we don't feel like we are competing.

This was not to say that competition and/or conflict did not exist. In some rural communities, community-based mental health organizations felt that they were competing with provincial employees. Prior to the reform, many rural areas were solely serviced by provincial government staff. With the arrival of community-based organizations, there were reports of territorial disagreements regarding responsibilities as highlighted by this

comment: "They [government staff] felt they could come and tell us what to do and how to do it".

In northern communities, mental health organizations cited the transfer of federal responsibility for health and employment services to provincial jurisdictions as the cause of confusion, if not competition, concerning who was responsible for providing services to First Nations people.

Relationships among community-based mental health organizations have not always been amicable. As one respondent described:

> With some we do not have a good relationship - but we don't have a bad relationship. We don't share the same philosophical bent.

Similar to Goodwin's (1990) analysis of the mental health community in Britain, the Manitoba mental health community was split between mental health organizations that emphasized the biological causes for mental illness and their corresponding medical interventions and those that emphasized the psycho-social causes of mental health problems and their corresponding interventions. There are clusters of related issues: "best interest vs client centered", "voluntary vs involuntary treatment", and "consumer vs professionally directed services". This philosophical split has manifested itself on a provincial and national level and has impacted the level of integration.

Government officials were aware of this division and had instructed organizations to ensure their philosophical differences did not interfere with their ability to serve the community:

> I mean from the Deputy Minister down, it has filtered down... We are sick and tired of the squabbling and turf fighting. So now, one of the buzz words of today is intersectorial. The government is driven that message home.

Community-based organizations were aware of the impact of not doing so, as reflected in these comments:

> We have a vested interest in working together to ensure that community-based service system works... if we don't make it work, the government may withdraw support.
>
> Competition is not seen as positive by government. They are not encouraging competition.

One organization in particular made a concerted effort to address this issue and believed that they were rewarded for doing so:

> We have maintained our distinctiveness, emphasizing the medical model, but have recognized the contribution of other disciplines in understanding mental illness. We have developed a more collaborative relationship. This approach has given us more credibility at large, with government and others.

There are other examples of the provincial government encouraging mental health organizations to work together. During the reform, representatives from both perspectives were included in the consultation process. The provincial government also entered into funding arrangements with mental health organizations from both perspectives. Finally, they did not follow a rigid tendering process and awarded the equivalent of multi year contracts thereby reducing the level of competition.

The situation may have changed with the arrival of the regional health authorities, as one executive director commented:

> Now there is no new money being spent, no more is being shifted from the institutional sector. Competition is going to increase. We are being told they have to wait for the Regional Health Authorities but they are not necessary going to have anymore money than has been made available to date.

To summarize, the level of integration did not decrease as a result of the increase in the number of community-based service providers delivering mental health services. Community organizations welcomed the additional services viewing them as a positive response to the high level of demand for service. When conflict and/or competition were evident, it was sparked by the mental health organization's differing perspectives. Whenever possible, the provincial government encouraged community-based organizations to work cooperatively, which was essential if they were to meet their objective of containing costs, maintaining legitimacy and continuity of care.

## Increased Bureaucracy

As indicated earlier, in comparison to government and/or institutional nonprofit organizations, the community-based organizations were smaller. Although, the scale or magnitude was not the same, community-based mental health organizations did not lack structure.

**Specialization of functions**

In all the organizations examined, paid staff and in some cases even volunteers, had distinct job descriptions, with detailed responsibilities, skills and educational requirements. Job descriptions could be categorized in three organizational functions:

- an organizational management function that included policy and program development, human resources management, and fiscal accountability.
- an administrative function that included reception, secretarial, accounting, and maintenance of office equipment and supplies.
- a service provision function that included the delivery of community development, public education, public relations, information, referral, self help, advocacy, service coordination, counseling, peer support, and rehabilitation services.

As expected, the larger organizations demonstrated increased specialization of job descriptions than smaller organization. This was particularly true for the executive director's position. In the smaller organization, the executive director often actively participated in all three functions as was the case in 42.8 % of the organizations. Logically, in larger organizations, the executive director was not involved in the service provision and some administrative functions such as reception.

Organizational charts revealed traditional hierarchical organizational structures. An example of a typical organization is included in Figure 1. The organizational chart represents 25 staff members in three programs and consists of five levels:

1) the Board of Directors,

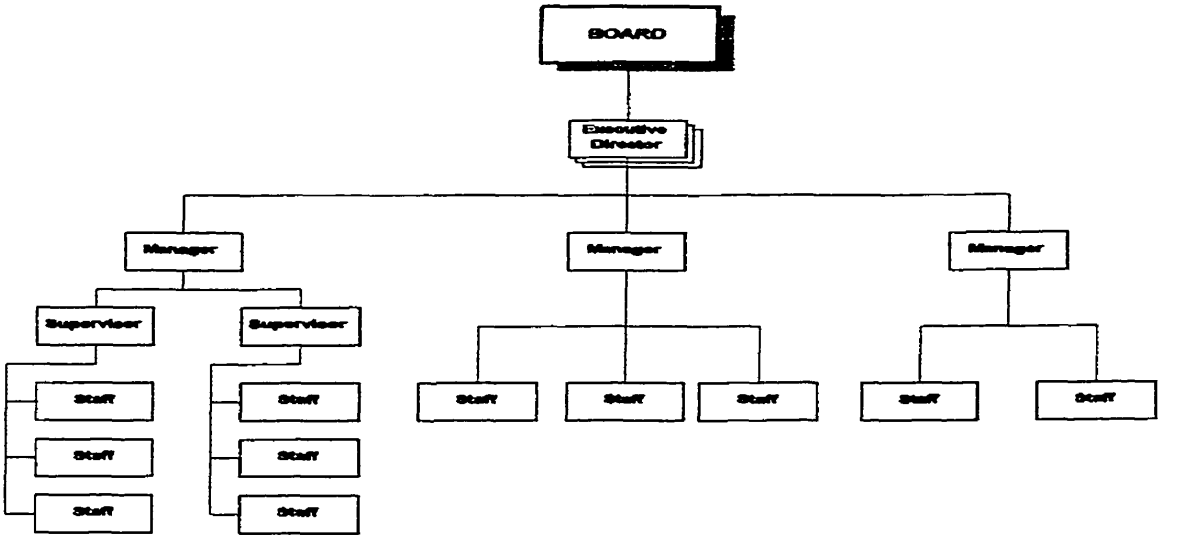
2) an Executive Director,

3) program mangers,

4) supervisors, and

5) administrative and service delivery staff.

**Figure 1 - An Example of an Organizational Chart of a Nonprofit Mental Health Organization**



As Table 14 shows, the bulk of the organizations had four structural levels or less. Even the smallest organization with only two staff members made a distinction between the manager and staff.

**Table 14 Number of Organizational Levels**

| Number of Levels | Percentage |
|---|---|
| 5 | 7.2% (1) |
| 4 | 50.0% (7) |
| 3 | 42.8% (6) |

Although site visits were not included in the original research proposal, they were conducted with 78.5% of the mental health organizations. This confirmed that these organizations were not informal structures. Reception areas were monitored for incoming clients and visitors. In most situations, there were separate areas designated for staff and clients. A system for leaving telephone messages was in place. Staff was required to account for their whereabouts either by a locator aid board or a log book. In the reception area, there were pamphlets describing the nonprofit organization's services. Applicable registration or application forms were available. Notices of standardized office hours, policies regarding smoking and the wearing of scent products, acceptable client conduct, and complaint procedures were evident.

In regard to written documents, organizations provided examples of policies and procedures on a variety of topics including; service standards, confidentially, working

alone, handling consumer complaints, application for service, intake criteria, waiting list maintenance procedures, the termination of services to clients, and the subsequent appeal process. Program descriptions detailing the goals, objectives and interventions employed were available. Staff related policies and procedures included job descriptions, performance evaluations, overtime accounts, reimbursement of expenditures and travel reimbursements, procedures for accounting for staff time and activities. Administration and accounting procedures described salary and pay scales, banking procedures, signing authority, annual audits. Minutes of board meetings, names and addresses of board and committee members, general membership lists, annual reports, and audited financial statements were also accessible.

When executive directors were asked, how much direction and support they were provided by the provincial government with their organizational development, they unanimously answered "very little" or "none". Brown, Troutt and Boame's (1999) research in Manitoba came to a similar conclusion. They reported that

> While government is, in general, the largest single funder of NPO's, it does not wield the most influence. Overall, in organizations who use volunteer labour, volunteers have more influence over NPO's decision making than do paid employees, government funding sources, corporate donors, or individual contributors (p. 28).

This was also consistent with Rekart's (1993) results, although in the case of the British Columbian research, there were varying views as to whether or not this was a positive outcome. Whereas, many of the Manitoba mental health organizations expressed

disappointment that the government did not provide more support as illustrated by these comments:

> We were on our own.
>
> They were very hands off.
>
> We were flying by the seat of our pants.
>
> Left to fend for ourselves.

There were only two examples of the provincial government directing organizations in regards of policy development. In these situations, the provincial government wrote organizations suggesting that they develop a process for dealing with service complaints and to ensure that they were aware of labour standard regulations as they relate to the payment of residential staff.

Even though executive directors described the government approach to their internal operations as "hands off", this does not mean that organizational structure was not affected by government funding arrangements. A significant level of consistent reliable income is necessary to sustain an organization. Administrators have speculated that an organization requires at least a $100,000 to establish some presence in the community (Testar, 1999). These funds enable them to rent space and equipment, plus engage at least one full time staff person. Without government support, most nonprofit organizations simply do not have the means to sustain an organization of any significance.

As revealed in the budget analysis, other income sources netted mental health organizations on average $44,000 a year. More than half (57%) of the organizations were unable to generate more than $50,000 from other sources while only 14% were able to generate more than $100,000. Clearly, the financial support received from the provincial government enabled organizations to hire staff and expand services. Consequently, a bureaucratic structure had to be developed as a means of managing the staff and services. As these comments illustrate:

> As our organization has grown bigger, our need for paper work has grown, required more internal detailing of information. For example, each worker outside of the main office provides us with a monthly detailed report.
>
> The organization had grown beyond our capacity to keep up. We need to hire an accountant with experience in computerized accounting system.
>
> So much administration and energy to get them up and running-- quite frankly we were are busy enough here without all that additional demands of running a larger organization... traveling to the Pas takes 12 hours alone.

In addition to the level of funding, the manner in which funding arrangements were awarded had an impact on the level of bureaucracy. By awarding funding arrangements to older, more established organizations, government officials were assured that an organization had a developed infrastructure and capacity to deliver services without appearing to interfere with the organization.

When executive directors needed direction, they sought management and administrative practices consistent with the nonprofit organization's value base.

> If you are focused on these values, it can be tough, sometimes, because you are consistently challenging yourself to answer the question-'How does this fit with our values? Does this fit our mission?'

They also consulted each other and/or contacted a variety of national and international association such as The Canadian Mental Health Association, Canadian Association of Mood Disorders, Canadian Schizophrenia Association, The International Association of Psychosocial Rehabilitation Practitioners, and Empowerment Center.

Federal and provincial legislation also dictated a variety of policies affecting how the organization treated staff and clients, reported income, accepted donations, paid taxes, raised funds, remunerated their director and officers, held land and received grants.

Finally, three organizations were unionized and as such were required to abide by collective agreements that detailed working conditions, salaries, and benefits.

To summarize, the influx of government funds and subsequent increases in the number of staff forced organizations to develop administrative structures, policies and procedures as a means of managing their organization. Rather than dictate how organizations should manage their services, the government awarded funding to well-established organizations that already had proven the ability to deliver services. Mental health organizations relied on their peers for direction than more the provincial government.

**Reductions in the Diversity of Organizations in the Nonprofit Sector**

The nonprofit, community-based, mental health sector in Manitoba is small, consisting of approximately 19 organizations throughout the province. The majority of these organizations were well established and had been delivering services for more than ten years.

Contrary to the speculation that provincial government funding arrangements would reduce the number of nonprofit organizations delivering services, the number of community-based organizations increased by two between 1993 and 1998. Besides substantially increasing the nonprofit organizations' revenue and their capacity to deliver services, the provincial government assisted several organizations in their development and ultimately their incorporation. In one rural area, where there was no community-based nonprofit organization to deliver mental health services, government staff was involved in recruiting board members to reestablish an organization that had been dormant for several years. In addition, several self-help organizations were provided with considerable support from government staff in their development.

After the research was completed, one organization lost its provincial government funding arrangement and subsequently disbanded. The reason for the termination of the funding arrangement was not made public.

In order to meet their objectives of a more community-based service system, the provincial government required a healthy nonprofit sector. Therefore, it was essential that they use administrative practices that encourage diversification and cooperation rather than competition. By awarding funding arrangements rather than tendering, the provincial government guaranteed the funding arrangements were evenly distributed among organizations with varying perspective, thereby providing consumers with choices while maintaining their legitimacy in the community. In short, government funding increased the number and diversity of the mental health organizations in the community.

# CHAPTER 9: The Verdict

Nonprofit organizations have changed dramatically in the last few years. The organizations delivering mental health services in Manitoba in the year 2000 are not the advocacy focused, community funded, volunteer dominated organizations of the early 1960's. They are profoundly different organizations whose focus has shifted from criticizing the service system to delivering services. Their traditional sources of revenue now constitute only 12% of their budget, while government and forprofit sources account for 88%. They are now more likely to hire staff than recruit volunteers. Finally, these new organizations have adopted more formal management methods for their significantly larger organizations.

Rather than remaining on the periphery of the service system advocating for systemic change, the nonprofit organizations have moved into the center of the community-based mental health service delivery system. In Manitoba, it is estimated that 65% of all community-based mental health services are now delivered by nonprofit organizations (Strutt, 1999). Nonprofit organizations participate in every aspect the service system. They create employment opportunities, provide housing options, intervene in crisis situations, educate the public, coordinate services, support clients, provide rehabilitation and render treatment. No longer concentrated in Winnipeg, they operate in every corner of Manitoba.

Donations and fund raising are no longer the mainstay of the nonprofit sector. Less than half of the sampled organizations relied on donations or fund-raising, as a revenue source and at levels significantly lower than what is required to remain viable. While participating in forprofit activity has become an increasingly popular option for some, for most, the solution to reduced revenues has been to embrace the provincial government's offer of a funding arrangement. It is estimated that since 1995, the Manitoba government, via the Departments of Health and Family Services, has awarded more than $6 million annually to community-based mental health nonprofit organizations in exchange for mental health service delivery.

Having assumed the responsibility for delivering services and given the additional financial resources to do so, nonprofit organizations did not recruit more volunteers. Instead, the number of paid staff was doubled. Organizational values and low funding levels meant more consumers, para professionals, part-time, as well as, causal staff were hired than full time professional staff. The demands of managing a larger staff that was, in some cases, dispersed throughout the province, forced organizations to adopt more structured ways of operating. Job descriptions, performance evaluations, and various human resource policies were developed in response. Driven more by a sense of responsibility to the community "to do a good job" rather than government directives, nonprofit organizations introduced a variety of management tools: service standards, complaint handling procedures, management information systems, and evaluation mechanisms. All of these contributed to an increase in the level of bureaucracy.

The most dramatic change has been the nonprofit organization's relationship with government. Much of the early literature portrayed the nonprofit sector as being independent, self supporting and critical of government services. In fact, the literature predicted dire consequences for nonprofit organizations competing for government funding including: distorted organizational goals, reduced accessability to services, diminished advocacy roles, bureaucratization, staffing implications and finally, financial concerns. Yet based on interviews conducted with executive directors of mental health organizations, it would appear that relations with the Manitoba provincial government were overall positive with minimal negative effects.

Why were the predictions in this case so wrong? Many of the predictions were based on the belief that government would require nonprofit organizations to compete annually for contracts that were awarded based on lowest bid, as well as, aggressively monitored. As the research revealed, this was not the case in Manitoba's mental health service sector.

Faced with the challenge of containing costs while maintaining legitimacy and control of the service system, the provincial government had difficult choices to make regarding their role in the delivery of health care services. Turning to the private sector was not a possibility since it was clear that the public was not prepared to accept a completely privatized health system. Furthermore, their own bureaucracy proved to be

very inflexible and unresponsive to changes. As well, they needed a containment strategy to address the demands of the public service unions if cost reduction was to be achieved.

The government's solution was the introduction of a "quasi market". By injecting a controlled amount of competition they were able to contain costs while at the same time maintain legitimacy with the public and control over the service sector. In order to achieve this critical balance, they separated the roles of purchaser and provider. While government maintained their role as purchaser, they contracted out the role of provider, in this case to the mental health nonprofit organizations (Le Grand, 1990, Culter & Waine, 1994).

To ensure that nonprofit organizations would participate, government included them in the implementation of the community-based mental health service system. Involving the nonprofit organizations provided the provincial government with an opportunity not only to assess the organizations' ability to deliver services, but also to "acculturalise" the organizations to the government's expectations. In addition, it was essential that nonprofit organizations assume "a sense of ownership" for the delivery of services, thereby allowing the government to extract itself from the demands of managing or monitoring the service delivery system.

By awarding rather than tendering funding arrangements, government could select the organizations to receive funding, thereby ensuring that organizations from varying

perspectives were represented and that services were distributed throughout the province. Strategically, it was also important that organizations who had "bought into" the vision could be "rewarded" with an offer of a funding arrangement.

Although, the mental health organizations' dependence on government financial resources appeared to give the government a tremendous amount of leverage, which had to be exercised carefully. They had to avoid the perception of being "heavy handed" for fear that organizations would withdraw. Awarding funding arrangements based on an organization's reputation for delivering services, willingness to work cooperatively and congruence with the provincial government's service delivery goals, enabled the provincial government to maintain a "hands off" policy with reference to the internal management of the organization. Furthermore, government officials would avoid the costs associated with aggressive monitoring and administration of contracts.

While significant efforts were made to move towards a standardized funding document, detailed service delivery outcomes were not included in the written agreement. Doing so would have implied that there was a consensus regarding the expected outcomes of a service. As well, it would have suggested that the provincial government had the resources to monitor and evaluate. In both instances, this was not the case. As the executive directors' comments illustrated, the provincial government was not prepared to define the expected outcomes nor was there an agreement among the nonprofit organizations as to what the outcomes should be. More importantly, additional

government staff could not be hired to monitor the funding arrangements if cost reductions were to be achieved with the implementation of a community-based service system.

Finally, by relying on their "relationship" with organizations, as well as, the nonprofit organizations' sense of responsibility to their consumers, the provincial government was able to preserve accountability without "interfering". The government's decision appears to have paid off. Mental health organizations had obviously internalized the importance of being accountable. Consistently, they developed policies and procedures, conducted performance appraisals, implemented management information systems, surveyed their stakeholders, and evaluated their programs with limited technical or financial resources. Such was their concern with accountability that they monitored each other's activities and reported concerns to government officials. In short, nonprofit organizations were very eager to be "good partners" and to "hold up their end of the bargain".

A closer examination of how the government managed their funding arrangements with respect to negative impacts, reveals that the situation is shifting. The marriage has evolved beyond the honeymoon stage, the negative impacts are beginning to materialize.

**Financial Implications**

Often it is argued that the sole option that governments have to reduce the cost of providing services is to employ the competitive model of funding administration and

tendering funding arrangements. As the budget analysis demonstrated, mental health organizations have not generated sufficient revenue from their traditional sources and have become depended on provincial government support. This dependence enabled the provincial government to contain costs without tendering, by employing two strategies. First, they focused negotiations on staff salaries. Since salaries traditionally constituted the majority of a nonprofit organization's budget, officials were able to contain the budget without protracted negotiations. In addition, the lack of strong union representation provided little leverage for staff at the bargaining table. By setting salaries across the sector, government also reduced the likelihood of staff movement from one organization to another seeking a better wage.

Secondly, after awarding the initial funding arrangement, the government held to their original arrangement and had not increase funding levels. Essentially, the government achieved savings without having the disruption, uncertainly and costs associated with tendering.

These negotiations may have not been the only government cost containment strategy. Entering into a partnership with the nonprofit sector may have also been a means of sending a message to their public service unions to limit their demands. If these new mental health services could be successfully delivered for less by nonprofit organizations, then other services could be transferred to this sector as well.

Even though the mental health organizations encountered fiscal problems with cash flow, inflexible budgets and unanticipated costs, they exhibited a willingness to make the necessary adjustments to address these issues. Recently, the impact of stagnant funding levels on the recruitment and retention of staff has forced some organizations to reconsider their position.

Squeezed by inflation, organizations turned to forprofit activities. Albeit, the level of activity was still insignificant as not to evoke a response from the business community. There were those who were concerned that the pursuit of commercial activities may lead nonprofit organizations to lose sight of their mission and ultimately, their legitimacy. It could be argued that their forprofit activities are more consistent with their goals than fund-raising activities that involve gambling or the consumption of alcohol beverages. In fact, forprofit activity enabled several organizations to achieve their organizational goals of providing work experiences for people with mental health problems and increasing their access to high quality housing.

Traditional revenue generating activities are not contributing sufficient resources to ensure that nonprofit organizations are able to deliver their services. If they want to remain significant service providers then they will have to accept government funds and/or locate other sources of revenue. Those organizations with multiple sources of revenue obviously have more leverage in the partnership than those totally dependent on government funding.

**Advocacy Role**

Various conclusions have been drawn regarding the factors leading to the "convergence of visions" between the provincial government and the mental health nonprofit sector whereby the community-based service delivery system was adopted as the ideal model of service delivery (Goodwin, 1990; Reckart, 1993). Nevertheless, the interviews with the executive directors demonstrated that once the provincial government decided to adopt a community-based service system and included the nonprofit organizations in the implementation, their relationship shifted from one of conflict to one of cooperation. Subsequently, the nonprofit organizations' focus shifted from advocating for change to delivering service. Yet, mental health organizations were adamant that their ability to advocate had not been compromised. In fact, most believed that their ability to advocate had been enhanced because their success in service delivery increased their credibility with government.

We are reminded of Salamon's (1987) claim that one of the weaknesses of the nonprofit sector is that of "particularism" - the tendency to have a narrow vision and focus on a particular subgroup to the exclusion of others. In Manitoba, it would appear that once the mental health organizations obtain funding to deliver their own services, they did not perceive systemic advocacy as a priority. On the other hand, this situation may also only be temporary. As one executive director pointed out, assuming the responsibility of service delivery has consumed all their energy and resources, leaving very little for systemic advocacy. Once they have established themselves in their new service delivery

role, they may resume their advocacy responsibilities. As well, if funding levels continue to be stagnant, it is conceivable that nonprofit organizations will be forced back into an advocacy role as means of ensuring their viability.

**Organizational Goals**

Although, it has been said several times, its worth repeating. Without government support, mental health organizations would have not been able to achieve their goals. The choice was very clear: accept the financial support or remain a marginal player in the mental health community.

As the interviews with the executive directors highlighted, once funding arrangements were awarded, government did not interfere in their operations. Instead of experiencing "diminished discretion" to make decisions as predicated by Kramer (1994), organizations often felt "left high and dry" to work out the details related to service delivery.

Theocratically, government officials knew the nonprofit organizations' capabilities and felt no need to dictate policy or procedures. They chose instead to maintain their legitimacy within the mental health community by enhancing the nonprofit organizations' ability to achieve their goals while maintaining control over broad policy objectives. At the same time, government reduced their exposure to cost and legitimacy concerns by

transferring the responsibility for managing direct services to the nonprofit sector. The Government of Manitoba achieved the best of both worlds.

**Client Accessability**

While overall client accessibility to services was enhanced as a result of increased resources, a stricter intake criterion was introduced by several nonprofit organizations. Ironically, the nonprofit organizations that had traditionally advocated for increased accessibility were now the "gatekeepers". Faced with changes in the client population and the need to demonstrate outcomes, mental health organizations responded in a manner that they thought government would want them to, they targeted their services. This is another example of government maintaining control over service delivery without direct intervention. Government had transferred "the hassles" of service delivery to the nonprofit organizations who in turn eagerly assumed the responsibility.

Unfortunately, this thesis's scope did not include interviewing mental health consumers. While the executive directors indicated that client accessibility was not reduced, consumers may have provided a different perspective. For example, most organizations were only able to provide services in English.

**Staffing Concerns**

As in other human service delivery organizations, 80% of the cost of delivering mental health services is salary, as such, funding levels are critical to the caliber and

number of the staff hired. Even though government funding for salaries was restricted, initially, it had a positive impact on the mental health organization's enabling them to double their staff. After a few years, nonprofit organizations experienced difficulty recruiting and retaining staff because of salary restrictions and stagnate funds. This was particularly true for organizations that hire professional staff. Recently, the shortage of nurses forced one award-winning mental health service to close its doors on several occasions. With salary levels significant lower (27%) than the institutional sector, the organization was unable to attract or retain the professional staff necessary to maintain service (Paul, 2000).

By handicapping an organization's ability to increase salaries, the provincial government may ultimately jeopardize their ability to deliver service. Unless the government is prepared to re-assume responsibility for service delivery, consideration should be given to readjusting funding levels.

**Integration of the Service System**

From the executive directors' perspective, the level of integration improved as a result of the reform. Mental health organizations cited examples of joint programming, reciprocated referrals and service coordination. Realistically, it would have been very difficult for mental health organizations to admit that the system was not working well, after having invested so much time and energy in the implementation of the community-based service system.

While the government guaranteed that nonprofit organizations would work cooperatively, not much attention was paid to the impact of "contracting out" of services on the relationship between the public service staff and nonprofit organizations. This was particularly evident in some of the rural areas where government staff chose not to refer clients to nonprofit organizations. It is not inconceivable that they realized that the government might be considering transferring other services to the nonprofit sector, thereby jeopardizing their jobs.

Although, funding of numerous and diverse organizations may have contained costs and ensured legitimacy, it does not necessarily ensure integrated services. Clients were often left to navigate their way through a complex multi sited service system in order to receive comprehensive service. Supporters would argue that multiple service providers promote consumer choice. This assumes that consumers can distinguish the differences between services and that a surplus of service exists. When the demand for service outstrips the supply, it results in long waiting lists for service (particularly for employment or housing programs). Desperate consumers will apply for several programs simultaneously and accept the first one that is available regardless of "fit" and participate. This analysis may have also benefitted from a consumer's perspective. However, this was beyond the scope of the thesis.

**Bureaucracy**

On the whole, the increase in bureaucracy was considered a positive outcome of the funding arrangements. Most organization's capacity to deliver service increased as a result of the influx of funding. But as one of the executive directors pointed out, "things would never be the same again". Gone were the days when business could be conducted in an informal manner. The increase in staff and accountability demands resulted in the formulation of written policies and procedures, delineated lines of authority and communication, as well as the introduction of managments information systems, thereby changing the organizational environment forever.

Traditional bureaucracy is often characterized as being close, inflexible, active, and focused on processes and rules. Whereas, the alternative forms of management are described as consultative, flexible, pro-active, focused on results and service standards (Wright and Rodal, 1997). Unfortunately, the nonprofit organizations discovered that it is not easy to be both consultative and pro-active, to adhere to service standards while maintaining flexibility, as well as reconciling these values with traditional principles such as fairness, consistency and financial prudence. In order to reconcile these often conflicting demands, nonprofit organizations sought assistance from the older and more experienced organizations in addition to their national associations.

Although nonprofit organizations experienced an increase in the level of bureaucracy, in comparison to government departments and institutions, they remain significantly smaller.

**The Number and Diversity of Nonprofit Organizations**

Prior to the provincial government's decision to shift to a community-based service system, the number and diversity of mental health organizations was severely restricted by their inability to generate sufficient revenues to maintain their viability. Yet a large and diverse mental health nonprofit sector was essential if government was to meet its objectives. In Manitoba, a diverse nonprofit sector was so important that it warranted direct involvement by provincial government staff in the development of approximately a third of the nonprofit mental health organizations. The majority of government staff-time was expended recruiting board members and supporting them in their early stages of development.

Why did government invest staff time to increase the size and diversity of the nonprofit sector? The lack of a consensus in the community with respect to mental health interventions required a diverse response. The organization's capacity to deliver services was limited. Multiple service providers encourage a limited amount of competition that would keep organizations vigilant. Organizations knew that if they did not perform well, others were available to assume responsibility for "their" service provision. Finally, a

scattered workforce also assured cost containment as unionization became increasingly difficult to achieve.

### Cost, Control and Legitimization

At the onset of this research it was proposed that governments choose to enter into a partnership with nonprofit organizations in order to address government concerns with containing service delivery costs, maintaining legitimacy with the public and ensuring control of the service delivery system (Goodwin, 1990). In this partnership, government would appropriate benefits not normally attainable by large bureaucratic structures: that of flexibility, innovation, responsiveness, and cost effectiveness. In turn, nonprofit organizations would gain the resources necessary to ensure: stability, accountability and consistency.

Initially, the research revealed that generally, the partnership benefitted both parties and in particular that there were minimal negative impacts for the nonprofit organizations. However, more recently, government's concern with containing costs has had major implications for the nonprofit organizations. As the government's focus has shifted, nonprofit organizations have begun to experience increasingly negative impacts. The inability to retain and recruit staff has impacted their ability to sustain the delivery of high quality service. Ultimately, the governments claim that a community-based service system is preferred, may lose its legitimacy with the public.

**Implications for the government and nonprofit partnership**

In the near future, it is doubtful if government will be re-assuming responsibility for the delivery of community-based mental health services. Nor is it likely that nonprofit organizations will be in a position to refuse further government funding. As such, it is essential that both parties work towards reducing the tension between government's attempts to contain costs, while maintaining accountability and the nonprofit organizations' desire to remain autonomous while dependent on government funding.

With this in mind, a group of unincorporated national voluntary organizations (Voluntary Sector Roundtable) asked a panel of respected Canadians to consult nationally with the volunteer sector (Brock, 2000). The Panel on Accountability and Governance in the Voluntary Sector (PAGVS), chaired by the Hon. Ed Broadbent, issued their final report Building on Strength: Improving Governance and Accountability in the Voluntary Sector in February 1999 which contained 41 recommendations to strengthen governance and accountability. Recommendations were not only directed to the nonprofit sector but also to both the federal and provincial governments.

Even though nonprofit organizations are the smaller partners in the partnership, they are not powerless. Nonprofit organizations need to recognize the government's objectives for what they are and avail themselves of a variety of strategies as a mean of counteracting the negative effects.

**Networking**

If nonprofit organizations want to continue to participate in this partnership, ways must be found to do so meaningfully. As Rekart (1993) pointed out, they must begin working together to consolidate their diversity in ways that are understandable not only to the government but also to the public. Nonprofit mental health organizations "must learn to act together in order to include their sector in a dialogue with authorities in such matters as value for money, accountability, fair practise, monitoring, and evaluation (Rekart, 1993, p. 150)". Both the Provincial and Winnipeg Regional Mental Health Councils have attempted to fulfill this role, but philosophical differences among the organizations have reduced their effectiveness. Unless mental health organizations find a way to speak with a united voice, their effectiveness will be reduced.

Mental health organizations could consider partnerships with nonprofit social and health service organizations. The complexity of the mental health consumer's needs warrants a diversified response. Partnerships with the organizations that address the issues of addictions, poor housing, lack of employment opportunities, poor medical services, inadequate counseling services and accessibility to alternative health treatments would benefit mental health consumers.

**Diversification of funding sources**

The scale of government funding to the nonprofit sector suggests that the future of this sector may be inextricably tied to government. Organizations that have other sources

of income while at the same time contracting to deliver services with a specific government department, obviously have more leverage in the partnership than those that are totally dependent on government funding. Organizations should attempt to diversity as much as possible. Ideally, they should seek non-government funding sources such as United Way or foundational grants. Entering into funding arrangements with more than one government department can be also advantageous, in that they are administrated independently of one another.

Recently, there has been concern expressed regarding the negative implications of nonprofit organizations participating in forprofit activity (PAGVS, 1999). On the other hand, our research demonstrated that forprofit activity provided a means for some nonprofit organizations to meet their organizational ends. As well, these activities were often more consistent with the organizational goals than the traditional fund-raising activities. Nonprofit organizations should consider the opportunities provided by the marketplace not only as a means of reducing their reliance on government funding but also as a means of improving the lives of mental health consumers. In Manitoba in particular, there are several very successful examples of nonprofit mental health organizations engaging in forprofit activity without compromising their principles. More importantly, they have produced positive outcomes for their clients.

**Outcomes and Accountability**

There has been considerable discussion regarding the need to demonstrate outcomes, yet, to date the provincial government has not articulated the expected outcomes of the funding arrangements. Nonprofit organizations should consider seizing this opportunity to decide as a sector which outcomes are achievable based on their resources and technology. Collectively, they could amass the resources necessary to access the required technical expertise.

This recommendation is consistent with that of The Panel of Accountability on Governance in the Voluntary Sector ( PAGVS, 1999) which called for the creation of a new Voluntary Sector Commission. One of the functions of the Volunteer Commission would be to provide support, information and advice on improving accountability. More immediately, organizations could consult several mental health organizations, who have successfully implemented a comprehensive psycho-social data collection system for evaluation purposes. Their experience may be of value to other organizations considering adopting a similar evaluation model.

**Labour Issues**

One of the driving forces behind the government's move to contract with nonprofit organization has been to circumvent the demands of the public servant unions (Culter and Waine, 1994). Given the fact that the recruitment and retention of staff is becoming increasingly difficult for nonprofit organizations and the prominence that government has

accorded the values accessability and continuity of care, nonprofit organizations need to present their concerns to government before their capacity to deliver service is jeopardized.

Non-unionized and scattered in small work sites throughout the province, nonprofit organization's staff has not been well served. Since their employers have gone into partnership with government, they may want to consider a partnership with the public service unions. The reality is that nonprofit organization's staff are not bargaining with the nonprofit organization nor the respective government departments. In actuality, they are bargaining with Treasury Board. Ultimately, Treasury Board approval is required to change staff salaries or benefit packages contained within the funding agreements. Unionization may be the only opportunity for staff to pressure the nonprofit organization to address this issue.

**Innovation**

The implementation of new services or even the modification of existing services in government departments is time consuming due to the multiple layers of decision making and protracted union negotiations. There is also the concern of the cost of implementing a province wide service. Transferring the service delivery to a nonprofit organization allowed government to pilot a service before implementing it on a larger scale. In addition, it also facilitated the targeting of services to meet a particular need. In turn, the nonprofit organization's location and size afforded more opportunities to identify

no longer participate in service delivery because of stagnant funding, government may lose access to a means of ensuring that mental health services are relevant, responsive and legitimate.

**Management Methods**

As the organizations grew and accountability demands increased, nonprofit organizations were challenged with finding new ways to management that are reconcilable with their values. In particular, the organization's want their management style to reflect the values that guide their work with clients: empowerment, self determination, particpatory decision-making, and strengths focused. The nonprofit organization would benefit from considering the work that had been done in the client centered social administration field. They provide many very concrete and practical ideas for bridge the gap between the work being done within the organization and that done in the community (Rapp & Poertner, 1992).

As the dominated partner, government has a responsibility, as well as, a vested interest in ensuring that this partnership continues to benefit both parties. Foremost, government needs to be reminded that this partnership with the nonprofit sector has afforded them access to a number of advantages of which cost containment is only one factor (Canada West, 2000, p.1).

**Mediating Function**

The nonprofit sector's role should not be restricted to providing a more economical means of delivering services. The mediating function that nonprofit organizations play when advocating on behalf of its marginalized community members, is essential if government is to maintain its legitimacy. Government needs to remove both the explicit and implied obstacles that hinder nonprofit organizations from becoming involved. In particular, the fear that they would loose their funding or charitable status needs to be addressed. In addition, government should publicly acknowledge that nonprofit organizations are integral to maintaining a democratic society.

**Policy**

Government must recognize that nonprofit organizations will not be satisfied with simply delivering services. Many of the organizations chose to participate in service delivery with the expectation that they would be included in the development of public policy. Government will have to make a concerted effort to include nonprofit organizations in policy decisions.

**Infrastructure**

Governments are responsible for ensuring that public dollars are spent in the most efficient and effective manner. Yet, they created accountability barriers that hinder organizations in achieving these goals. First, they restricted the movement of dollars within budgets (between salaries and operations). Secondly, they disallowed the

accumulation or retention of surplus by the nonprofit organizations. The removal of these barriers would empower organizations to make better decisions regarding the distribution of their resources. It would also provide nonprofit organizations with the means to accumulate funds, improve their infrastructure and increase their organizational capacity to delivery service.

**Enhanced Tax Incentives**

Even though, the most recent tax data available demonstrated that Canadians donated over $3 billion to charities, it falls short of what is required to be viable. (Sharpe, 1994). Recognizing the need to improve the tax incentives, in their 1997 budget, the federal government increased an individual's allowable tax credit against a charitable donation to 75 % of their annual income, up from the previous limit of 50 %. As well as, they extended the income limitation to all charities. Despite these changes, there is still room for improvement. The tax system needs to find efficient, equitable and simple means of encouraging charitable donations from citizens and corporations ( Scharf et al. 2000).

In closing, although government's concern with cost containment is still viewed as the primary reason governments choose to enter into a funding agreement with the nonprofit sector, their need to maintain legitimacy and control over the service system is also critical to the equation. When government fails to maintain this balance, major

implications occur, not only for the nonprofit sector but also for the government and their ability to achieve their objectives.

# Appendices

**APPENDIX A - Interview Schedule**

Date of Interview:

Identity Code:

**Introduction:**

Your organization is representative of those providing mental health services in the community. As the key executive officer of the organization I am seeking your perspective.

Funding Arrangement

1. I would like to start by discussing your current funding arrangements with the provincial government. I am going to describe to you three common types of provincial funding arrangements. I would like you to choose the one that best describes your funding arrangement.

*Types of Funding*

*Grants are funds made available to community organizations to encourage the development of alternative, community-based services. Commonly organizations apply for grants which are provided to organizations whose goals and objectives best match government priorities. In exchange, the organization provides an annual report detailing its activities and finances.*

*Service Agreements are written agreements in which government funding is provided in exchange for a specific service to a targeted group of consumers. Commonly, organizations are invited as a group or approached individually to submit a proposal detailing how they would deliver a specific service. In exchange, organization accountability is limited to providing activity reports and audited financial statements.*

*Purchase of Service Contracts (POSC) are also written agreements between the government and organization whereby an organization provides a specific service in exchange for funding. POSC 's are more specific, in that they may detail the type, volume, consumer and expected outcomes of the service to be provided. In addition, the POSC may contain evaluation requirements and have been awarded as a result of a tendering process.*

2. Would you describe how your organization first obtained provincial government funds? How long have you been receiving them?

*Probe - Did they respond to official advertisements (request for proposal)? If the organization competed with other organizations? Was the arrangement a result of a tendering process?*

*Were they contacted by the ministry and asked to submit a proposal/tender? Or did they approach the ministry with a proposal?*

3. How often is your funding arrangement renegotiated/renewed? Was the process the same every time? Has it changed in the last five years?

4. Could you describe the document that details your present funding arrangements with the provincial government? Make sure to distinguish from the proposal submitted and document detailing the funding arrangement?

*Probe: Length, Level of specificity? Does it include the following: client numbers, targeted client group, intervention used, staff qualifications, use of volunteers*

5. Do any of your funding arrangement documents contain guidelines on the following?

| | yes | by whom | no |
|---|---|---|---|
| staff # | | | |
| staff/client ratios | | | |
| volunteer # | | | |
| salary ranges | | | |
| intake criteria | | | |
| service standards | | | |
| recording formats | | | |
| confidentiality procedures | | | |
| type and amount of service to be provided | | | |
| # of clients to be served | | | |
| expected outcomes | | | |
| other | | | |

Does your funding agreement/contract specify how you are to handle the following?

| | Yes | If Yes, describe | No |
|---|---|---|---|
| surplus funds | | | |
| deficits | | | |
| reserves | | | |
| capital | | | |
| Fund-raising | | | |
| | | | |

6. How has this document changed in the last five years?

7. In general terms, have you noticed any changes/shifts in the funding arrangements since 1992?

8. Generally, what factors do you believe are responsible for these shifts/changes?

9. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**ADVOCACY ROLE**

10. How would you describe your organization's (board and staff) activities in **systematic advocacy** - advocating government for changes to the mental health service system? Conflict or cooperative? Could you describe some of the activities your organization has been involved in?

11. Has the nature or the extent of these activities changed in the last five years?

12. What factors do you believe influenced these changes?

13. Do you think that provincial government funding arrangements have had any impact on your systematic advocacy activities? If so, could you describe how?

14. Have you made any changes to these activities as a result of provincial government funding arrangements?

15. Could you describe your organization's involvement in **individual advocacy** - your staff advocating government agencies on behalf of clients to access other services?

16. Have you noticed any changes in regards to the nature or extent of your organization's involvement in individual advocacy in the last five years?

*Probe increase or decrease in activity, with what departments? and what are the issues? availability service or benefits ie income security, health benefits, level of service.*

17. What do you believe is responsible for these changes?

18. More specifically, do you think your funding arrangements with the provincial government have had any impact in the nature or extent of your organizations individual advocacy activities?

19. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**ADMISSION CRITERIA**

20. If someone wanted to make use of your organization's services, how would they access them?

*Probe if the admission requirements vary within organization differ? Can an individual self refer or do they need to be referred by a professional? Are they required to have a clinical diagnosis? Are their application forms? Intake process? Are their waiting lists? how long?*

23. More specifically, were these changes influenced by your provincial funding arrangements?

24. Have you noticed any changes in your client group in the last five years?

*Probe for number of clients being served by your organization? (Increased, decreased, remained the same? Are client numbers available for 1992-1996)? Severity of their problems?*

25. What factors do you believe are responsible for these changes?

26. More specifically have your provincial funding arrangements had any impact on these changes?
*Probe for has your provincial government funding allowed you to increase the number of clients resulted in working with more difficult clients?*

27. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**PROFESSIONALIZATION**

28. In the last five years have the following items - increased, decreased, remained the same?

| | increased | decreased | same | d/k |
|---|---|---|---|---|
| # of regular full time staff | | | | |
| #of regular part time staff | | | | |
| # of volunteers in direct service positions | | | | |
| # of volunteers in office/clerical positions | | | | |
| #caseload numbers | | | | |

29. In the last five years, has your organization implemented or changed any of the following:

| | Yes | No | factors |
|---|---|---|---|
| qualifications, education or experiences required by direct service staff | | | |
| job descriptions | | | |
| professional development or training programs | | | |
| staff performance appraisals | | | |
| replace full time staff with part time staff | | | |
| replace full time staff with contract staff | | | |
| performance related pay | | | |
| wage freezes | | | |
| layoffs | | | |

| | | | |
|---|---|---|---|
| voluntary redundancies | | | |
| unionize | | | *when |
| labour management team | | | |
| management training | | | |
| Other | | | |

30. Could you describe what factors you believe were responsible for implementing these changes?

31. More specifically, did your provincial government funding arrangement have impact on the decision to implement these changes?

32. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**LEVEL OF BUREAUCRACY**

33. Could you describe how your funding arrangement is monitored by provincial government officials? More specifically, could you detail the types and numbers of reports you are required to submit to the provincial government as result of your funding arrangements? *Probe for organizational service and activities, finances, outcomes.*

34. Have there been any changes in how you are monitored in the last five years?

35. What factors are responsible for these changes?

36. In the last five has your organizations changed or implemented any of the following:

| | yes | no | other |
|---|---|---|---|
| Strategic planning | | | |
| Performance/outcome indicators | | | |
| Information technology /Management Information Systems | | | |
| Consumer feedback /client satisfaction surveys | | | |
| Periodic in-house program evaluations | | | |
| External consultants commissioned by organization | | | |
| Evaluations required by external body | | | |
| Other | | | |

37. What factors were responsible for influencing your decision to do so?

38. More specifically, did your funding agreement influence your decision to make these changes?

39. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**GOAL AND MISSION SHIFT**

40. Has your organization made any changes in the range and/or type of services provided in the last five years?

41. What factors influenced the decision to change the services provided by your organization?

42. Were these changes influenced by your funding arrangement?

43. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**INTEGRATION**

44. How would you describe your relationship with other community-based nonprofit organizations providing mental health services? Cooperative or Competitive?

45. Could your give me examples of organizational behavior that would demonstrate this? Are you involved in joint programming, case consultation, reciprocal referrals?

46. Has your relationship with other community organization changed in the last five years? If so, describe how?

47. What factors have impacted your relationship with other organizations?

48. More specifically, have your provincial funding arrangements affected your relationship with these organizations?

49. Generally, how have these changes been beneficial or problematic for your organization and its clients?

**BUDGET**

50. Indicate the amount and type of funding your organization received from the following for each fiscal year listed. If this information can be obtained from your annual report or audited statements, please provide a copy.

| Funding Source | 1992 | 1993 | 1994 | 1995 | 1996 |
|---|---|---|---|---|---|
| Provincial Gov. | | | | | |
| • Health | | | | | |
| • Family Services | | | | | |
| • Other | | | | | |
| Federal Gov. | | | | | |
| | | | | | |
| United Way | | | | | |
| Fund Raising | | | | | |
| Fee for Service | | | | | |
| Donations | | | | | |
| Memberships | | | | | |
| Other | | | | | |
| | | | | | |
| Total Budget | | | | | |

51. Having reviewed you budget, could you describe any trends or changes in the last five years?

52. Generally what factor do you believe are responsible for these changes in your budget?

53. Specifically, how has your funding arrangement with the provincial government affected changes in the budget?

54. Have you encountered any budgetary problems: Cash flow? Unexpected costs such as consultant fees, introduction of new technology, staff benefits, underestimated costs for facilities? Salaries? Decreased Fund raising?
Inflexibility budgets? e.g. unable to move budget items? Other budgetary problems? Describe?

55. Have you encountered any budgetary benefits as a result of your government funding arrangement, such as: Increased level and quality of service. Increase staff salary? Stabilized funding? Other?

56. What factors have been responsible for these problems or benefits?

57. More specifically, how have your provincial funding arrangements been problematic or beneficial as it related to your finances?

**CONCLUSION**

58. We have discussed a number of changes. Have you notices any changes that have not been discussed?

59. How would you rate the importance of following the above changes that you have mentioned?

**APPENDIX B - Recruitment Letter**

Dear

I am a graduate student at the University of Manitoba, Faculty of Social Work, Social Administration Stream. I am presently conducting research on the extent of purchase of service contracting with the provincial government and its impact on community-based nonprofit organizations providing mental health services in Manitoba.

As part of my research, I am interviewing the Executive Directors of nonprofit organizations who receive funding from the provincial government. As such, I would like the opportunity to interview you to gather your perceptions regarding the impact of government funding on your organization.

The nonprofit sector is facing many new opportunities and challenges including shifts in the nature of government funding. In order to respond in a way that will benefit our organizations and our clients we need to have a clearer picture of what the implications of these shifts are. I believe sharing your experiences will be of great benefit to other organizations and I hope you will agree to participate in my research.

I will be contacting you in the next two weeks to set a time for the interview. The interview would take approximately an hour to an hour and half. With your approval, I would like to tape the interview. I have enclosed a copy of the interview questions so you may review them before the interview.

I assure you every effort will be made to maintain your organization's confidentiality. The tape, documents and notes will be kept in a locked filing cabinet until I have completed my research at which time the tapes will be disposed of. The research data will be transcribed, analyzed and reported with the goal of maintaining your organizations' confidentiality.

My research is being supervised by Professor Pete Hudson, Dr. Sid Frankel of the Faculty of Social Work and Professor Paul Thomas of the Department of Political Science. If you have any questions, please call me at xxx-xxxx (work) or at xxx-xxxx (home).

Yours Sincerely,

Daniela Evenson

**APPENDIX C - The Consent Form**

I understand that:

- the goal of this study is to explore the extent and impact of purchase of service contracting on community-based nonprofit organizations receiving government funds to provide mental health services in Manitoba.

- I have been selected as a research participants because I am the executive director/program manger of a nonprofit organization.

- I will not be paid for my involvement in the research project.

- I will be interviewed for an hour and half to two hours regarding my perceptions.

- the interview will be taped by Daniela Evenson and transcribed by Daniela or a professional who is experienced working with confidential materials.

- I can refuse to answer any question(s), ask that the tape recorder be turned off and/or stop the interview at anytime, I wish to do so, without any recourse.

- the tapes will be kept in a locked filing cabinet until the research has been completed and Daniela Evenson's thesis has been accepted by her committee, at which time, the tapes will be destroyed.

- research findings will be summarized and presented without identifying research participants.

- I understand every precaution will be taken to ensure the interview material will be kept confidential, but I also acknowledge that based on number of nonprofit organizations delivering mental health services in Manitoba, the researcher's ability to maintain the organization's anonymity is limited.

- Upon request, Daniela Evenson will provide me with a summary of the study findings at no cost.

- Daniela Evenson can be contacted by phoning xxx-xxxx or writing her at xx xxxxxxxx xxxx, Winnipeg, Man. xxx xxx.

Based on this knowledge, I agree to participate in this study

_____

Signed and dated

# APPENDIX D - Funding Information Package

Manitoba

Health

Finance and Administration
Services Division

P.O. Box 925
599 Empress Street
Winnipeg MB R3C 2T6

January 31, 1997

**EXECUTIVE DIRECTORS**
**ORGANIZATIONS IN RECEIPT OF FUNDING FROM MANITOBA HEALTH**

The Department requests information regarding your organization, programs and budget to support external agency funding in 1997/98. Enclosed is the "Funding Information Requirement Package". Although it does not differ from the package which you received last year, please review its contents. A brief description of the type of information required to complete each part is as follows:

**PART A: BASIC INFORMATION**

The basic information required in Part A deals with the identification of your organization and the organization structure. It is recognized that these areas are subject to change; therefore, to ensure that our records are correct, please complete Sections 1 and 2 in full.

If your organization is planning to make changes to the organization and/or structure during the 1997/98 fiscal year, please identify the planned changes including a statement of how the changes will impact upon each funded program's goals and objectives. The identification of changes will be in addition to the basic information requested in Section 1 and 2.

If during the last year your organization has undergone changes to its LEGAL STATUS, HISTORY OR PERSONNEL POLICIES, please report the changes along with your submission of Part A information.

**PART B: PROGRAM INFORMATION**

**SECTION I:**

Section I requires a listing of ALL programs operated by your organization and a listing of ALL funding sources.

**SECTION II:**

Section II requires detailed program information for all programs where Manitoba Health funding will be requested in 1997/98. Each sub-section (1-11) must be completed in full.

Please utilize the prescribed format, if one has been specified by the program branch, e.g., Services to Seniors, Mental Health Self Help.

If your organization is planning to make changes other than those organization or structural changes mentioned above to any program funded by Manitoba Health, please identify the changes including a statement explaining the impact that the changes will have on the funded program's goals and objectives.

# MANITOBA HEALTH
# FUNDING INFORMATION REQUIREMENT PACKAGE

## PART A: BASIC INFORMATION

Please provide the following information for the current year.

**1. IDENTIFICATION:**

a) Legal Name of Organization
b) Full Mailing Address
c) Telephone Number(s)
d) Fax Number(s)
e0 Organization's Purpose
f) Geographic Area of Operation

**2. ORGANIZATIONAL STRUCTURE:**

a) Names of Officers and Board Members
b) List of Board Committees and Membership
c) Name of Executive Director
d) Organizational chart showing reporting lines
e) List of operational locations (name, address, phone & fax #)

**3. ANNUAL REPORT AND AUDITED FINANCIAL STATEMENTS:**

Please submit a copy of your annual report and a copy of your audited financial statements no later than three months after your year-end.

**PLEASE REPORT CHANGES/UPDATES ONLY IN ANY OF THE FOLLOWING AREAS:**

4. Legal Status

5. History

6. Personnel Policies and/or Union Agreements

## PART B: PROGRAM INFORMATION

### Section I:

List all programs operated by your agency and their funding sources.

### Section II:

Please complete sub-sections 1-11 for each program where funding is requested from Manitoba Health.

1) Program Name

2) Target Population

3) Geographic Area

4) What are the needs that the program is to address?

5) What are the objectives and the intended results?

6) Describe program activities.

7) For each program activity explain how the output statistics will be recorded i.e., number of people served, number of visits made, number of meals served etc. If a form of measurement has been specified by Manitoba Health, that form of measurement should be used.

   All information should be in a **comparative format** such as:

| Last Years Actual | Current Year Planned | Current Year Revised | Next Year Projected |
|---|---|---|---|

8) What have been the three most important changes in your organization over the past three years? What caused the changes?

   Are there any key trends in the community that will have an impact on the program? If yes, please specify and outline how your organization intends to respond.

9) Describe the criteria for measuring the effectiveness of the program.

   How effective has each program been at meeting its objectives during the past year?

10a) Within the existing funding level what changes (if any) could be made to increase program effectiveness and how could these changes be made.

b) Do you plan to phase out, provide new, modify or expand programs and services or provide services to a new target population? If yes, please explain how the changes will affect funding requirements.

c) If these changes cannot be made within the existing funding level what are the funding requirements in order to make these changes?

11) Identify organizations in the community that offer a similar or complimentary program. How do you work with these organizations?

## PART C: 1997/98 BUDGET

### Section 1 - Budget Submission

The 1997/98 budget submission should be for the same level of funding that was approved in 1996/97. If planned program changes identified in Part B require additional funding, a separate budget should be submitted for the difference. Requests for additional funding will be handled separate and apart from your regular budget submission.

For each program funded by Manitoba Health please ensure that the budget submission includes:

a) All sources of revenue whether private, public or a combination thereof, including the funds requested from Manitoba Health.
b) All program costs and;
c) Where any of your organizational costs are allocated between programs supported by Manitoba Health and those not supported by Manitoba Health, please provide the detail on total organizational cost and the formula used for allocation of such costs.

For your convenience, budget sheets have been enclosed to assist you in your budget preparation. For agencies whose budget has been computerized, please ensure that you have captured all of the information outlined on the blank sheets.

**Please submit the package in duplicate to Manitoba Health, Finance and Administration, 599 Empress Street, Winnipeg, Manitoba, R3C 2T6, Attention: Agencies, no later than March 31, 1997.**

### Section II - Audited Statement

Audited financial statements should be submitted to the Department no later than three months after your year-end. The audited statements should be for your entire organization. Programs funded by Manitoba Health should be shown separately within the audited statements. Your 1997/98 budget approval will await receipt of the 1996/97 audited financial statements.

We are again enclosing the current Agency Reporting Requirements. Please retain these for future reference. Please remember to complete the "Year-End Staffing Report" and attach it to the audited financial statements on an annual basis.

If you require further clarification, do not hesitate to call your Agency Relations Coordinator, Miggie Lampe at 786-7327 or Georgina Wall at 786-7278.

Susan Murphy,
Director, Finance & Administration

Encl

## PART C: BUDGET

THE 1996/97 APPROVED BUDGET FIGURES ARE TO BE USED IN THE APPROVED BUDGET CURRENT YEAR COLUMN. PREPARE YOUR 1997/98 BUDGET AT THE FUNDING LEVEL APPROVED IN 1996/97.

1. **SUMMARY SHEET** (Page 1)
   Each total generated on pages 2-5 is carried forward to the "Request for New Year Column" on the Summary Sheet.

2. **SALARY DETAIL** (Page 2)
   All positions are to be listed individually.

3. **STAFF BENEFITS** (Page 3)
   Statutory Deductions are to be shown separately i.e., C.P.P., U.I.C., Workers Compensation.

4. **OPERATING EXPENSES** (Page 4)
   Expenses are to be listed individually. All expenses are to be shown GROSS not NET.

   **Non-Recurring**: These are "one time only" increases/decreases not associated with program expansion.

   **Price Increase/Decrease**: These are price changes.

   **Expansion/Reduction**: These increases/decreases are a result of program expansion or reduction.

5. **Program Revenue** (Page 5)
   All revenue is to be listed by source.

6. **Explanation Sheet** (Page 6)
   Explanations as required for significant changes.

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