Mental Illness and Substance Abuse (MISA)

Service Delivery Pilot

The concept for this project stems from an identified workforce deficit in the treatment and support of people experiencing both mental health and substance use problems.

The objectives of the project are (i) to enhance the capacity of non government drug and alcohol services to provide both drug and alcohol and mental health services to their client populations and (ii) to enhance the capacity of non government mental health services to provide both mental health and drug and alcohol services to their client population.

The rationale for undertaking this project is the increasing number of clients presenting with mental illness and substance use issues to non government agencies; poor linkages between non government drug and alcohol agencies and non government mental health agencies and lack of cohesive strategies to address the situation coupled with a commitment to finding practical solutions.

Expected outcomes include: increased organizational capacity to address MISA issues; increased worker capacity and confidence to address MISA issues; improved service for clients and improved linkages between non government mental health agencies and drug and alcohol agencies.

Background

People living with a mental illness are at an increased risk of developing problematic alcohol or drug use. 1 *(Commonwealth Department of Health & Aged Care (2000).* Prevalence rates of substance abuse issues in mental health settings have been consistently reported at between 30 and 80 percent. 2 *(Todd, F.C., Sellman, D. & Robertson, P.J. (2002).* Also, studies have shown that more than half of the people who use or abuse substances have experienced psychiatric symptoms significant enough to fulfill diagnostic criteria for a mental illness. 3 *(Regier et al., 1990).* Despite the demonstrated high prevalence of dual diagnosis in mental illness and substance abuse (MISA), service delivery systems often fail to adequately meet the needs of this group. 4 *(Burdekin, 1993, cited in Tobin et al., 2001).*

Since the issue of dual diagnosis first began to emerge in the mid 1980s, treatment providers have “bounced” MISA clients from service to service in what became known as “ping, pong therapy”. 5 *(McKey,1998 cited in Hegarty, M. 2004).* At a service level, treatment for individuals with MISA has traditionally been provided in separate mental health and alcohol and other drug programs in serial or “parallel” fashion. 6 *(Judd et al., 2003 cited in Hegarty, M. 2004).* MISA service users must negotiate between the two systems, with differing philosophical approaches and are often excluded from both. In a 2000 survey of Australian mental health and alcohol and drug services, staff indicated a problem in the co-ordination of client care across services, including disputes over duty of care. 7 *(Kavanagh et al., 2000).* Another Australian survey of service providers, identified barriers to effective treatment of MISA including: lack of liaison between services, lack of community resources, high workloads, and lack of knowledge and expertise. 8 *(Byrne et al., 2000b).*

Dual diagnosis (MISA) is associated with a host of social, behavioural, psychological and physical problems, including: increased symptom severity and suicidal behaviour; greater non-compliance with treatment; more hostile and aggressive behaviours; increased risk of

violence to others; higher rates of offending, imprisonment and homelessness, and longer duration of admission to psychiatric inpatient units. [9] *(Hegarty, 2004)* Because outcomes for comorbid patients tend to be poor within the systems designed to treat single disorders, there is increasing literature discussing possible interaction between the services. [10,11] *(Kessler et al., 1996; Ries, 1993).*

The National Drug and Alcohol Research Centre in its 2003 study on comorbid mental disorders and substance use disorders, [12] *(Teeson & Proudfoot 2003)* identified three models of service provision: serial treatment, parallel treatment and integrated treatment. Serial treatment involves treating one disorder before treating the other. In non-acute cases, having two independent systems treating serially in this way means that many people with comorbid disorders "fall between the cracks", being treated by neither system as neither sees it as their responsibility. [13] (Ries, 1993). Parallel treatment involves being treated for one disorder at the same time as receiving treatment for another. The treatment response to drug and alcohol and mental disorders in many developed countries has been dominated by parallel systems. There is a wealth of evidence documenting the fact that the traditional methods for treating substance use do not work for clients with psychiatric disorders. [14] *(Woody, McLellan, & O'Brien, 1990; Proudfoot & Teesson, 2000).* Integrated treatment has been proposed as the likely solution to some of the problems presented by the older models of parallel and serial treatment. [15] *(Bellack & Gearon, 1998; Carey, 1996)*

'Caught in the Gap', a recent research project conducted by the NSW Association for Adolescent health [16] *(NAAH 2003)* highlights the difficulties organisations face in treating people with mental illness and substance abuse (MISA) issues. In mental health services, people are treated as sick and assertively followed up whereas in Alcohol and Other Drug (AOD) services only people who are motivated and want to change can access services. [17] *(Webster 2001)* In addition many service providers struggle to cope when a primary diagnosis is unclear. Mental health services have traditionally felt that any AOD issue requires treatment and management prior to understanding the mental health issues and the reverse has been true for AOD services. Such conflicting or different philosophies and perspectives influence the provision of services in the mental health and AOD sectors and it is recognised many MISA clients fall through the gap receiving inadequate and patchy care and treatment from both kinds of agencies.

Various studies have pointed towards the need for integrated treatment systems for MISA clients. [18] *(Drake 1998, Kavanagh 2001, Todd, Seman, Robertson 2002)* This project aims to pilot a model able to deliver an integrated system of treatment and care by establishing collaborative partnerships between specialist NGOs currently working in either the mental health or AOD sectors.

Project Design

The integrated treatment approach has substantial implications for workforce development. Under this model training, organisational systems and practices must develop to accommodate new ways of understanding and working with individuals presenting to both mental health and drug and alcohol community based treatment, rehabilitation and support services.

The project proposed entails development of a memorandum of understanding between the mental health and drug and alcohol peak bodies, the Network of Alcohol and other Drugs (NADA) and the Mental Health Coordinating Council (MHCC). Project funding is secured through the NSW Health Center for Drug and Alcohol.

The service delivery pilot sites are selected from participating organizations from respective peak body membership who would engage in a capacity building service

delivery process focused on partnership between organizations located in close geographic proximity. Three to four pilots are proposed:

- 1 metropolitan based mental health residential rehabilitation service and 1 metropolitan based drug and alcohol residential rehabilitation service.
- 1 rural based mental health residential rehabilitation service and 1 rural based drug and alcohol residential rehabilitation service.
- 1 women specific mental health service and 1 women specific drug and alcohol service.
- 1 youth specific mental health service and 1 youth specific drug and alcohol service in close geographic proximity

The service delivery pilots would involve a reorientation of services within a capacity building framework to incorporate either a drug and alcohol or mental health focus. Re orientating a service is essentially a process of organizational change for the purpose of achieving better health and wellbeing outcomes for service users. 19 *(Gray & Casey, 1995).* Improved staff satisfaction and commitment is an additional benefit which further enhances service provision.

The term 'capacity building' is variously used but in this project the term is used to encompass the problem solving capability of individuals and organizations whereby they develop a range of skills to overcome barriers to the provision of holistic care and treatment.

The NSW Health Department 20 *(Hawe et al., 2000)* has developed a strategic framework for building capacity within an organization which is useful not only in structuring key components but in its focus on sustainability which is fundamental to the project objectives. The framework has four main components:

- *workforce development* : up-skilling of workforce, staff commitment, reframing current practice and tailoring intervention activities to the local context.

- *organizational development*: management support, reference group to guide activities, an organizational culture that supports the approach, fit within the policy structure of each of the agencies, absorption of approach into the agency's everyday practices, agencies ability to problem solve.

- *partnerships and linkages*: formal interagency partnerships, informal links with other agencies, interest in actrivities from other agencies, community interest and support for the approach.

- *allocated resources*: dedicated driver of the initiative, funding to support activities, access to information and specialist advice. 21 *(O'Hanlon et al., 2002)*

This framework was used by the Australian Network for Promotion, Prevention and Early Intervention (Auseinet) in *Building Capacity for mental health.* 22 *(O'Hanlon et al.,*2002) In 1998 Ausienet provided seed funding and intensive support to eight agencies that provided services to young people to reorient an aspect of their service to an early intervention approach to mental health. The aim was to give the agencies the opportunity to build capacity by developing a range of tailored, potentially sustainable strategies. In November 2001 a follow up evaluation was conducted to determine the extent to which the strategies that were developed in the reorientation projects had been sustained or expanded; to identify opportunities for and barriers to reorientating services to an early intervention approach; and to identify factors which may be useful in predicting sustainable change within an organization.

Importantly two of the eight projects were partnership projects between two agencies and the learnings from the experience of these two agencies is relevant to the proposed MISA service delivery pilot project. In particular, the partnership between the Hunter Mental Health Service (HMHS) and the NSW Department of Community Services (DoCS) is informative as both agencies operate within different philosophies. HMHS functions from a medical model but incorporates early intervention thinking and practices whereas DoCS functions from a crisis model. The project facilitated these two agencies to work together towards the common goal of providing better services to children whose primary carer has a mental illness. It sought to reorient child protection casework and community mental health clinical intervention into a collaborative program in which knowledge, skills and resources were shared. 23 *(O'Hanlon et al.,*2002). The project evaluation details project outcomes against the strategic framework for building capacity and in addition examines barriers and sustainability issues.

Further detailed information about the strategies used to establish the reorientation projects appears in *Model projects for early intervention in mental health of young people: Reorientation of services.* 24 *(O'Hanlon et al, 2000)* This document describes the rationale for the reorientation projects, the selection of the agencies and the methods used to train and support the reorientation officers. It includes background information on each agency, describes their reorientation strategies and discusses the opportunities and barriers encountered. It concludes with an overview of strategies within a capacity building framework and a discussion of lessons learned from the reorientation process.

Another interesting initiative which has developed a partnership approach to building capacity comes from an unexpected source but shares a number of relevant learnings. It is a Sister City project between Orange City Council and Mount Hagen in Papua New Guinea. The partnership has existed for some 15 years. The framework for the partnership describes shifts in approach:

Shift from	To
Competition	Collaboration in loose forms
Acceptance of subservient role	Ownership and control
Ignorance of options and a sense of panic	Shared commitments and actions
Mistrust and Fear	To spiralling trust
Isolated learning	Group learning
Static social capital	Capacity building
Static structures	Flexible structures
North - south	South - south

Stephen Sykes who is Director of Enterprise Services, Orange City Council and Chairperson Regional Tourism Organisation (NSW - Central West) refers to the work of Sykes and Fulop,1999, who describe the collaborative process as a type of collective learning - with the stakeholders discovering, reflecting, redefining and rediscovering the meanings of the labels on an inter-organisational plane. 25 *(Sykes & Fulop, 1999)* Sykes goes on to comment that learning in an organisation is complex and multifaceted; the complexity is multiplied by stakeholders operating from different perspectives in an inter-

organisational and inter-cultural context. Empowerment of the stakeholders was seen as crucial in building relationships among unlikely partners and creating new norms to govern their interaction' 26 *(Schruijer in Gray 1999).*

Collaboration is viewed under the framework as needing to develop from a voluntary basis and exist as an organic process, meaning it grows to meet the needs of the stakeholders. The role of talking and discourse was seen as pivotal to the success of the Sister City arrangement. Spiralling commitment and goodwill as well as extensive inter-organisational learning and development of social capital were understood to be outcomes. Power was understood to have been exercised with a view to achieving a win/win outcome between the stakeholders. The diagram below illustrates the dynamics of collaborative planning. 27 *(Sykes, S. 2001)*

The valuable learning from this initiative in relation to the MISA service delivery pilot project is that collaboration leading to empowerment cannot grow from imposed structures as this will not engender a sense of ownership amongst stakeholders and the collaboration will fail.

Evaluation

Understanding and being able to demonstrate success and failure within a pilot project is essential. The proposed MISA service delivery pilot project will require an evaluation component that incorporates evaluation of the process and impact of the pilot and sustainability of the initiative. The process component will look at how and why things occurred, the context in which the initiative is implemented (eg. effectiveness of consultation and training processes); the impact component will explore what was achieved in the short term (eg. service level agreements, appropriate policies and procedures and reported increases in capacity of workers to address MISA issues); and the sustainability component will look at how the initiative will impact over time.

Given this an action inquiry strategy seems to be the most applicable and effective approach. The process of action inquiry as equips organisations for dealing with future challenges and transformational change. It is an iterative, cyclical process of improved knowledge through action and revised or new action through reflection. The action-reflection cycle resembles a spiral in which the knowledge and expertise of management can provide an evolving body of wisdom. 28 *(Ellis & Kiely 2000)* Action inquiry strategies are a way of bridging the gap between theory and practice and addressing the pressing problems of a quickly changing world. 29 *(Greenwood & Levin, 1998)*

Ellis and Kiely have written an article for Action Research International which examines the value of action inquiry in tackling organisational problems in real time. They identify four key features which are broadly common to all action inquiry approaches: (i) the way social reality is constructed; (ii) the enablement of change; (iii) co-inquiry process; and (iv) iterative cycles within the inquiry. Ellis and Kiely go on to explain the four approaches to action inquiry which need to be considered in order to understand which approach best fits an organisation's 'fitness for purpose'. The four approaches are: action research; participatory action research; action science and action learning. Each is discussed in relation to the level of risk that may be incurred in their application both in terms of individual and organizational vulnerability. 'Participatory action research' is identified as the approach carrying the most risk for individuals and the organization and 'action science' the greatest risk to individuals. Risk associated with 'action learning' tends to be contained within specific activities and 'action research' allows for greater control and oversight by management resulting in relatively low risk status for individuals as well as at the organizational level. 30 *(Ellis & Kiely 2000)*

Workforce Issues

The MISA service delivery pilot project sits within a wider context of workforce development for non government organizations working with people affected by mental illness and drug and alcohol problems. Workforce development aims to ensure that service delivery is characterised by quality, innovation and evidence based practice. It purports that investment in staff training is unlikely to be effective unless there are structures and systems in place in the workplace that support and reinforce the content of training.

Exploring models of workforce development and developing strategies that could be realistically applied to assist organisations reach objectives and endear confidence from funding partners is needed in the sector. The MISA service delivery pilot project is an attempt to explore a partnership model of workforce development within the sector.

Underlying the important process issues around workforce development models and strategies however, lies the far more challenging and complex area of human resource management. The MISA Service Delivery Pilot Project requires a reorientation of service direction and challenges cultural assumptions about the best or right way of delivering care and treatment by asking participating organizations to change their orientation by broadening their perceptions and deepening their knowledge and understanding of their field of endeavor. 31 *(Gray &Casey 1995).* Adherence to culture within an organization can be extremely strong. It is used both as a right of passage for devotees and a defensive pattern against which those wishing to challenge it may be repelled, or if more compliant, converted. In NSW as in other states and territories, there has existed a strong territorial division between mental health and AOD services both within NGOs and within acute care services. A reorientation of service response must understand and address this issue if an integrated service system is to be established in the first instance and be sustained in the second. Over time differences in practices, language, values, beliefs and exclusion criteria have developed within two separate systems, each more focused towards defining and meeting the needs of workers, training facilities, funding bodies and policy writers than towards the clients requiring care and treatment.

What is needed to re orientate both mental health and AOD services to incorporate the needs of clients with a MISA diagnosis is a collaborative approach – an approach that can only be brought about by a transformational leadership response. Transformational leadership ‘requires skillful management of adherence to a collectively established vision and a set of core values upon which the stakeholders have reached consensus’ 32 *(Dovey 2005).*

Transformational leadership requires development of a legitimizing narrative upon which collective action becomes possible. This can best be understood within a radical humanist frame which argues that sustained change cannot simply be applied to an organization but must develop with reference to the historical circumstances of the organization, the strength of the interests held by the status quo and the actions of the proponents and opponents of prevailing organizational structures. 33 *(Dovey, 2005)*

NGOs are well placed to engage in transformational leadership around service provision to people who experience both mental illness and substance abuse. Generally speaking, NGOs are able to be more flexible and responsive in meeting perceived need because of their size and organizational structure. Public Mental Health and Drug and Alcohol Services have been unable to fully progress a collaborative response to MISA clients. Reasons for this include the restrictive specialist practices of the medical disciplines that manage care in both areas and the tendency to create silos at the departmental level in response to competition over financial resources.

Whilst NGOs also compete for scant resources they are generally speaking, more open to collaboration because of their commitment to community development and able to provide holistic care and support in a way that the specialization intrinsic in medically based interventions cannot. NGOs are more able to incorporate different ways of working because they are more dialectic in their approach, more able to engage in transformation through relationships that demonstrate mutual respect and commitment, a requirement of collective human action and, in this instance, organizational change. 34 *(Dovey, 2005)*

In terms of transformational leadership the understanding that mental health and AOD NGOs working collaboratively are well placed to provide people experiencing mental illness and substance abuse the care and support they need is the legitimizing narrative that underpins the more structural issues of organizational engagement and management. The story of how people with MISA have been marginalized serves to highlight the way forward and is crucial in shifting the gaze of AOD and mental health NGO workers towards the possibilities inherent in the collaborative process.

Collective recognition of the legitimacy of any undertaking establishes the cultural and operational parameters of organizational life. It is fundamental to reorientation of an organization as it is here that resistance to transformational leadership is most deeply embedded. One approach is to understand the process as a convenant. That is the achievement of a sense of shared destiny among organizational members where there is an acceptance and sharing of the risks, responsibility and rewards. 35 *(Etzioni, 1998)* Intrinsic to this is belief that what happens is not outside individual control; that individuals are responsible for what happens and not passive participants.

The relationship between creating a vision around which members can coalesce and which has meaning for their lives and identification and promotion of a culture that supports the attainment of that vision is key to successful and sustained implementation of the project objectives. However, unless there is strong leadership within the organization and structural processes developed that align with the shared vision the legitimacy of the undertaking will become confused and eventually breed resentment amongst organizational members.

Trust amongst stakeholders is fundamental to project success. The building of trust entails the opportunity to identify and discuss the core values that support the practices and organizing principles of the shared vision. Leadership must ensure that dialogue on shared understanding is sustained continuously within structured communication channels. This process serves not only to build trust among stakeholders but also serves to enhance sustainability of the project objectives by providing a framework for action and performance assessment and hence a means of learning and innovation. 36 *(Johnson &Wilson, 2000)*

The development of communication channels between the organizations involved in the pilot project areas is to be structured in such a way as to allow participants to investigate assumptions behind the approaches taken by each organization and each team member. As referred to earlier mental health and AOD services have very different philosophies that motivate there approach to service delivery. Whereas 'compliance to treatment' motivates the mental health approach, 'readiness to engage' motivates the AOD approach. These approaches are not necessarily mutually exclusive and examination of the assumptions and historical underpinnings of each is a valuable learning tool that can result in innovation in service delivery.

Key to sustainable partnership development is the need to establish and achieve agreement on the roles and responsibilities of participants. This is to ensure there is accountability and adherence to agreed actions and the ability to attribute the outcomes of actions thus enabling further learning and innovation. 37 *(Johnson &Wilson, 2000)* Given

the potentially conflicting nature of elements underlying the collaboration process in the pilot partnerships it is important that there is open and participatory engagement by all participants and an understanding that the process they are engaged in is not static but rather an action research/ learning process involving the coordination and cooperation of organizations. 38 *(Ellis & Kiely 2000).* The focus must be on participants consciously trying to achieve accommodation of their different interests whilst trying to find a methodology within which their interests can be accommodated. The resulting methodology is where the innovation from collaboration registers and also where new understandings and consensus develop in the treatment and care of people experiencing mental health and substance abuse issues within NGO services.

Whilst the value of participatory management cannot be understated in developing the framework of the project, there is evidence that in and of itself it is not able to ensure the successful reorientation required. Chief executive leadership and environmental factors within the participating organizations are equally vital. Evidence suggests that if the chief executive is not fully committed to the project initiative the reorientation is likely to fail. 39 *(Durst & Newell 2001)*

This is an important recognition for project planners in choosing the participating organizations. It is not adequate to simply pick two organizations in close geographic location that fit into the categories designated in the funding and performance agreement. Extensive interviews will need to be conducted to allow project planners to assess the commitment of the CEOs and to understand any environmental factors within the organizations that may inhibit the process of reorientation. Such factors as inability to demonstrate a learning or quality improvement orientation within a service or rigid intake procedures and exclusion criteria and poor demonstration of community linkages may place an organization in the unsuitable basket for participation in the pilot project.

As previously noted, organizational reorientation requires more than just a technical shift. It requires a cultural shift which must occur from the bottom up as well as the top down if program sustainability is to be achieved. Predicators of sustainability include workforce development, organizational development, resource allocation and partnership formation and maintenance. 40 *(O'Hanlon et al 2002)* Understanding the underpinnings of sustainability helps conceptualize the project elements and provides a framework for evaluation.

Below is a table which details the elements of each component of sustainability and identifies some of the barriers or possible obstacles that may be experienced in the project implementation process.

Predictors of Sustainability	Barriers and Considerations
Workforce Development - up-skilling of workforce to a level of competency in both AOD and mental health - staff commitment to organizational reorientation to incorporate MISA clients - reframing current practice to a MISA approach - tailoring MISA interventions to the local context	- high staff turnover will effect the ability of NGOs to engage with MISA clients - high workloads can mean reorientation to MISA clients is viewed as 'added work' rather than 'more effective work' - change weary staff - unrealistic expectations of the partner NGO - confidence in ability to work with MISA clients

	- flexibility to gear services to the local environment will hold more success than attempting to overlay pre determined protocols on NGOs - management level development and training is crucial to achieving organizational commitment to the reorientation process - joint training in how to work with other NGOs could be an important mechanism to articulate concerns and build trust and committment
Organisational Development - management support for MISA activities - reference group to guide MISA activities - an organizational culture that supports integration of MISA - fit of MISA activities with the policy structure of the agency - absorption of MISA into the organizations everyday practices - organizations ability to problem solve	- sustained focus on the 'vision' may be difficult within an NGO if management presence and commitment strays - resistance from individuals and other organizations who fear the therapeutic bases to which they currently adhere will be lost - establishment of a reference group to guide activities has the added advantage of promoting the project across agencies - NGOs that already operate within a learning environment will find integration of MISA clients easier than those who don't - absorption of MISA protocols into the existing policy framework and organizational structures of an NGO will enhance sustainability - creativity and flexibility are key qualities in overcoming barriers thrown up during the process of reorientation
Resource Allocation - dedicated driver of MISA activities - funding to support initiatives - access to information and specialist advice	- a dedicated driver from management within the participating NGOs must be identified to work alongside the project officer - a plan to determine the ongoing resources needs of the reorientation process must be developed in partnership with participating NGOs - the development of resource kits on MISA and policy templates to assist NGOs would be a valuable aid as long as local initiative and processes could be incorporated
Partnership formation and maintenance - formal interagency partnerships - interest in activities from other	- difficult access to specialist acute care services when needed may

agencies - community interest and support for MISA activities	mean 'starting over' or failing with individual MISA clients - sharing the reorientation process with NGOs not participating in the pilot projects in structured forums is important to create flow on effects and manage misinformation

The Mental Illness and Substance Abuse Service Delivery Pilot Project was conceived between two peak bodies both equally aware of the severe under servicing of people with mental illness who also abused drugs and/or alcohol. The inability of public health services to engage this group of individuals in more than a piecemeal way has been widely reported and understood but action to rectify the barriers are slow to materialize. The NGO sector has opportunity to demonstrate that where there are complex needs NGOs have the flexibility to develop appropriate collaborative partnerships that allow creative solutions. Solutions that go beyond therapeutic interventions to focus on whole of life issues whose impact on symptomotology is now readily accepted by even the most conservative medical professional. Caution is needed in the approach we take to the initiative however, as there are many pit-holes which if not carefully negotiated will undermine our best intentions. Human resource management is not the least of these. Adherence to one code appears to be a strong instinct in people generally and the philosophies that underpin both mental health and AOD service delivery are fundamental to the way services are delivered. Being aware of the barriers and considerations in the management of human resources, when formulating the project work plan, will contribute to successful implementation of what is a very exciting and valuable initiative.

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