Building a learning organisation in a child and adolescent mental health service

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Abstract

In recent business literature, the model of the learning organisation has been proposed as a solution to the problem of continually changing environments and increasing consumer expectations of maximum quality and value for money. The model seems highly appropriate for health services, which are staffed by educated professional staff who must become more adaptive and concerned with improving consumer outcomes. This case study describes how the principles of learning organisations have been applied to the design of a new structure and the creation of a learning culture within a mental health service for children and adolescents.

Introduction

Victorian Child and Adolescent Mental Health Services (CAMHS) are managed by acute hospitals. They consist of multidisciplinary teams of medical, allied health and nursing staff who provide young people with assessments and treatment interventions directed at biological, psychological and social levels (Rutter 1975). Victorian CAMHS have been criticised recently for their conservative practices, inward orientation and relatively poor performance in quality improvement activities, outcome measurement and research (Department of Health and Community Services 1996). These perceptions suggest that CAMHS need to become more consumer-oriented and interested in learning about the outcomes of their interventions. This view has recently been echoed by Bickman (1997), who has urged all Australian mental health services to adopt a culture of outcome measurement and continuous improvement.

Some organisational models, cultures and infrastructures support experimentation and innovation more than others (Argyris 1991). Nevis, Di Bella & Gould (1995) recently described how workplaces may be designed for adaptation through creating a learning culture internally, and encouraging feedback loops between learning teams and their environment. Such arrangements may drive ongoing change and performance improvement in an organisation, its members and the environment (Garvin 1993; Chowanec 1994). The concept of a learning organisation (Garratt 1987) has been given new impetus by the work of Peter Senge and colleagues (1990; 1994) at the Sloan School of Management, Massachusetts Institute of Technology. The idea of organisations which facilitate the learning of their members and continuously transform themselves in response to environmental change has enormous contemporary appeal, as evidenced by an exponential rise in publications on this topic between 1990 and 1996.

This paper describes a case study of the author as director, attempting to build a learning culture and a client-focused service infrastructure in a Victorian CAMHS during a period of 18 months. It outlines a general view of change and proposes a normative template for a learning mental health organisation that was successfully applied. An action research approach to change was used, which itself aimed to create an aligned structure and culture supporting ongoing organisational learning. Thus the goals of change and the processes used were both related to the experiential learning cycle described by Kolb (1984), with its recursive steps of experimentation, observation, theorising and planning, followed by further action.

Change management

Professionally staffed health services are generally thought to require participative approaches to implementing change (Kinston 1983; Bridges 1986; Dunphy & Stace 1990; Marshall & Yorks 1994). Conner (1992) warns that the price of not building commitment initially will be the later emergence of different kinds of resistance. Thus the author began the process of engaging key staff in a new vision and minimising resistance by introducing them to the idea of learning organisations and inviting their assistance to build one (Senge 1990; Kotter 1995).

The culture of an organisation influences work practices (Handy 1993), the action theories people hold about the world (Argyris 1993), how internal and external relationships are seen and managed, and how knowledge is acquired and shared (Kemmis & McTaggart 1988). This concept of culture is anthropological, and refers to the overarching integrative pattern of shared ideas, values, practices

and linguistic devices that create social reality for group members (Sackmann 1991). The cultural domain may be poorly understood by action-oriented managers as it is less tangible than structure (Ghoshal & Bartlett 1995). However, culture may be continually observed, and also influenced, by change agents who address the experiences, actions, assumptions and beliefs of workers (Schein 1993).

Because external change triggers perturbations in the internal psychological domain, and this is emotionally uncomfortable, opposition to change is inevitable (Bridges 1986). To be successful, planned organisational change needs to address each of the following levels concurrently (Kemmis & McTaggart 1988):

- culture – the language, discourse, and currency of values within a workplace
- work practices – work design, staff training and development, defining responsibilities
- structure – hierarchy, teams, roles and the infrastructure required for new relationships.

As director, the author had authority to question current practices, communicate the need for change, identify the values that characterised a mental health learning organisation, engage cooperation for the new vision, and orient staff to mutually desirable goals in the change process (Schneider, Brief & Guzzo 1996). He worked most closely with the management team, but involved all staff in several extended staff meetings which were used to identify priority areas for change, set goals and review progress.

Using action research

Action research is an appropriate methodology for cooperative social change, with its steps of planning, action, and evaluation of the results of action by participants (Thornber 1992; Greenwood 1994). It has been widely used in management training (Margerison 1988; Newton & Wilkinson 1994), and has been described by Prideaux (1990) as the systematic application of action learning principles to simultaneously implement change in a real organisational situation, and learn about the organisation and the self from the process. Prior to the project, the management literature was reviewed to identify the characteristics of learning organisations. This material was organised into the dimensions of leadership, organisational design, work design, and the structure and cultural elements that supported the learning cycle (perception, thinking and planning, coordinated action and motivation).

Table 1: Characteristics of learning organisations

Organisational element	Structure and culture
Leadership	A daring and compelling vision is developed by all members, and is open to reshaping and redefinition. The vision includes a focus on clients and quality improvement. Individual and organisational values and goals are aligned. The leadership role is spread throughout the organisation.
Organisational design	Roles and authority are reassessed to reduce layers of management. Horizontal hierarchies emphasise cooperation and collaboration over line control. Unit tasks and work roles are aligned and designed for coordination and synchrony (for example, cross-unit teams). Individuals are encouraged to explore how their actions and decisions affect colleagues and external customers.
Work design	Individual jobs relate to the whole, creating synergy and interdependence. Little goal divergence but a large degree of process divergence is tolerated. Staff development and team development is built into work. Work is seen as an opportunity for continuous problem-solving and learning. Constraints related to learning, problem-solving and risk-taking are specifically sought, identified and removed.
Perception	Systems are established to collect data about consumer needs and effects of work done by organisational members. Individuals are open to feedback and information about the results of action. Learning from others occurs through benchmarking, conferences, visiting other centres, and listening to peers and customers. Experimentation is supported in new ways of organising work, project-based learning, and tolerating mistakes.
Information processing	Tools for systematic problem-solving and planning are introduced to organise and analyse data (for example, Case Review Checklists). Core learning skills are developed (for example, brainstorming, dialogue, debate, questioning). Opportunities are created for group reflection processes which review experience. Learning is encouraged through sharing perceptions, experiences and values in a safe supportive environment.
Communication	Diversity of views, dissent, and openness to ideas are encouraged and difference is appreciated. Two-way communication between staff is valued and nurtured as a vehicle for learning and development. Knowledge transfer is built into the organisation through sharing experiences in team meetings, staff rotations, conferences and visits. Group planning precedes the implementation of new actions which will involve everyone.
Motivational systems	Goals include creativity, experimentation, learning, reflection and continual improvement. Individuals feel involved in a community and relate in mutually beneficial ways. Coaching skills are developed in managers and supervisors and there is a high degree of trust and tolerance of error. Staff are valued as autonomous, developing, self-motivated individuals. The culture is based on ethics and values of wonder, humility and compassion. Honesty, responsibility and integrity are valued. Successes are noted and celebrated.

Source: Senge 1990; Mink 1992; Jones & Hendry 1992; Garvin 1993; Bennett & O'Brien 1994; Campbell & Cairns 1994; Daniels 1994; Di Bella 1995

The results of this are shown in Table 1, which formed an organisational template which would be used to guide the change project. However, the first major stream of action steps in the project began with an attempt to co-create a new vision for the service with staff by presenting them with information about learning organisations, discussing the deeper values which would underpin an adaptive client-centred service, and involving them in imagining what such an entity might look like (Morgan 1993). From this process, a more general description emerged which provided personally meaningful goals for staff to hold in mind while we worked to develop our new organisation:

- Feedback loops would provide data about consumer needs and work outcomes.
- Heuristic tools and processes would be developed to enable staff to think systemically and render their underlying assumptions and hypotheses more accessible.
- The shared practice of collective thinking skills, dialogue and debate would help to identify the most critical questions and add value to possible solutions.
- The service would aim to improve consumer learning strategies, evaluation and research.
- The experience of participating in these processes would be psychologically satisfying and support trust and playfulness among team members.

The vision of the service became:

Continually improving services to children and adolescents through evaluating, learning and innovating in partnership with our community.

Among the core values explicated by senior staff were a commitment to personal and organisational development; a wish for mutual support, connection and caring in a context of continual change and stressful work; a preference for collaboration over isolated action; a desire to use evidence-based best practice, and curiosity about how to create a more effective service. Table 2 provides a more detailed description of this imagined future service, which evolved over the first six months of the project. It links values and beliefs with concrete behaviour, and has provided a framework against which the service could evaluate its own progress towards becoming a learning organisation.

Table 2. Linking values and beliefs with behaviour in a learning CAMHS

Values and beliefs	Behaviours
Clinical services will be consumer-focused and client-oriented.	• Consumer feedback to clinicians will be sought by several means. • Improvement in client satisfaction levels will occur. • Specific clinical programs will be designed for particular patient populations.
The service will be committed to learning and improving treatment models and practices.	• Research programs will be established which emphasise outcome evaluation, improved efficiency and effectiveness. • Routine outcome measurement and feedback mechanisms will be established. • Specialist clinical programs will be established which involve most staff.
Clinical work and research will be entwined to achieve 'state of the art' practice.	• New services based on research elsewhere will be established and evaluated. • Specialist clinical programs will explore new social learning strategies for clients. • Research program reports will occupy part of clinical staff development.
Team-orientation will enhance coordination, learning and commitment.	• Staff development will include focus on group dialogue and teamwork skills. • Peer review of clinical work will be introduced. • Staff will be actively involved in team clinical meetings, quality improvement activities, and clinical review processes.
Service structures will be designed to enhance cohesion, and diminish irrelevant conflict.	• The management group will create a vision for the service which will be open to development by other staff. • Discipline and sub centre interests will be secondary to service goals.
Staff will be committed to systemic thinking, conceptualisation and exploration of underlying theoretical models.	• Staff meetings will be characterised by questioning, debate and dialogue in an exploratory and non-combative manner. • Assumptions will be surfaced and everything will be open to question and exploration.
Staff commitment will be enhanced through a sense of shared group purpose, open communication and support for personal development.	• Clinical and research work outputs will compare well with other CAMHS. • Unplanned staff turnover will be low. • Team meetings will be characterised by playfulness, humour and good attendance.

Aligning structure and culture for a learning mental health service

Another major element of the change strategy was organisational redesign to enhance cohesion, coherence and alignment, develop staff commitment (Jones & Hendry 1992; Garvin 1993) and support a learning culture (Mink 1992; Nanus 1992). Both structure and culture had to encourage learning and experimentation by groups of clinicians (Schein 1993; Di Bella 1995; Nevis, Di Bella & Gould 1995), aimed at improving outcomes for clients (Bickman 1997). Each of the key steps for group learning and coordinated action shown in Figure 1 had to be considered and built into the work experience, that is, data collection, analysis, joint decision-taking and implementation.

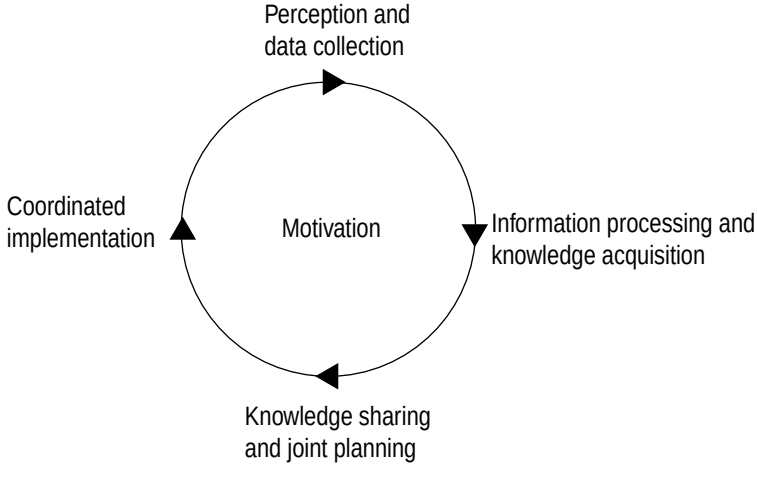

Figure 1: The Group Learning Cycle (after Kolb 1984)

Structural change included establishing a research and evaluation unit by creating three half-time academic positions, developing alliances with two universities to promote research activity and support the development of an information system, and appointing good staff. This unit has obtained several research grants, is exploring clinical assessment tools in several comparative studies, and is now trialing outcome measures. The organisational structure is flat to enhance participation and sharing of authority and responsibility (Ghoshal & Bartlett 1995), and the practice of the management team is to actively encourage questions and evaluation. There are three multidisciplinary community (outpatient) mental health teams, each responsible for services to a particular geographical area, although staff from these teams contribute to specialist programs or clinics for specific disorders. Clinical reviews occur weekly in team meetings, in special interest groups and in supervision. All staff meet for a weekly

scientific and clinical staff development meeting and monthly staff meetings. Voluntary participation in a new monthly forum helps generate ideas on improving patient allocation, workload management, assessment or treatment practices.

Building a management team

Instead of constructing the management team from the head of each professional discipline, a product-line management structure was designed to support the functional activities and units of the service (Charns & Tewksbury 1991; Health Care Advisory Board 1995). Clinical service units are led by team leaders, appointed from senior clinicians in the service. Their clinical case load is reduced to create the time required for management and administrative roles, but additional remuneration is not available. The service products are episodes of care made up of clinical contacts, and community development activities (consultation or education) delivered through outpatient teams and the research unit staff. Community activities are coordinated by a community program manager within a community plan (Department of Health and Community Services 1996). Inpatient and day-patient programs opened in late 1997, and are integrated with outpatient services as the case manager retains responsibility before, during and after admission. Intermediate products are clinical management information, case records and text communication for coordinating care, and staff development to improve clinician skills.

While the director retained responsibility for determining the appropriate mix of clinical programs, clinical team leaders were each invited to take responsibility for a functional portfolio which related to an intermediate product of the whole service, in addition to operational team management. These were the community program, case records and continuous quality improvement activities, monitoring and evaluation including information system development, staff development and research. This portfolio system has worked well, and has led to the development of focused plans in each area, as well as ensuring that the teams shared common understandings and were involved in developments. The senior staff member of each discipline is responsible for staff selection, supervision and the maintenance of professional standards, but holds no budgetary responsibility.

Leadership and partnership

Senge (1990) and others consider that leadership is possibly the single most important element in establishing a learning organisation (for example, Ghoshal & Bartlett 1995; Jones & Hendry 1992; McGill, Slocum & Lei 1992). Post-modern views of manager–professional employee relationships assign increasing importance to how managers support and empower work colleagues (for example, Block 1993; Quinn, Anderson & Finkelstein 1996). 'Directing' is one side of a hierarchical relationship, which is more completely described as a 'leader–follower' relationship (Bateson 1972). In the author's experience, such relationships are frequently characterised by defensive behaviour, especially when conflict is undeclared, trust is low, and hierarchical structures are imposed on highly educated workers (Smith 1982; Marshall & Yorks 1994).

The literature suggests that work practices are improved when leaders share responsibility and authority for change, align organisational and team goals, gain commitment through setting joint goals, and stimulate staff by asking questions and rewarding effort (Drucker 1988; Conner 1992; McGill, Slocum & Lei 1992; Ghoshal & Bartlett 1995; Kotter 1995; Porter-O'Grady 1996). Success in these activities is increased when leaders monitor their own internal states and behaviour, and note the impact they have on their colleagues (Argyris 1993). Learning is improved by reflection, keeping a journal, reviewing the meanings of events with a learning team (Daudelin 1996), and by using a mentor, coach or supervisor to improve the validity of one's observations and explanations (for example, Senge 1990; Argyris 1993; Vogt 1995). During the project the author sought feedback from others, encouraged comment about interpersonal behaviour and its effects, and requested assistance when necessary (see Ryan 1995).

Communication, dialogue and debate

As a further stream of organisational change, the management team and all clinical staff have invested time to develop skills in dialogue and skilful discussion (Senge 1990). Senge considers that dialogue, or the practice of freely externalising thoughts within a group conversation, is the key to group thinking and learning. In dialogue, group members focus on understanding what is being said, instead of judging others or planning their response. Dialogue is not the same as discussion or debate, although these are valid and useful for problem-solving and decision-making, when group members understand each other well enough to be talking the same language (Senge at al. 1994). Dialogue arises because several people choose to adopt an open and explorative attitude in order to understand something better. While some authors (Schein 1993; Senge et al. 1994)

recommend the use of a facilitator to begin dialogue, once a group experiences dialogue the process seems to be self-reinforcing.

When regularly practised, dialogue is said to deepen the relationship between individuals, build a sense of community, meet spiritual and affiliative needs, and increase commitment to the work task (Kofman & Senge 1993; Zemke 1996). Early in this project, the management team met for two half days to develop a vision for the service and define interlinked goals for each of their portfolios. Over the following year, all staff were involved in setting workload benchmarks, developing a staff manual, establishing case review and peer supervision mechanisms, training in assessment and case planning, introducing a new case allocation system, and implementing quality outcome measures. Consequent work practice changes have reduced waiting lists from over six months to approximately six weeks for non-urgent cases, with quality now being measured to ensure it does not lessen.

Building in the learning cycle

1. Data gathering and perception

A learning health organisation must invest in tools and processes to collect and channel data about the results of clinical practices for appropriate information processing. Computer-based information systems are essential to provide readily retrievable data about the results of staff activity (Applegate, Cash & Mills 1988), so a clinical information system was developed. As outcomes are an increasingly important focus for all health funding bodies, utilitarian outcome measures are being developed in many places to provide feedback about the effectiveness and efficiency of service units (Thornicroft & Tansella 1996). Since all instruments have methodological limitations, it is accepted that practice experience is necessary to define the extent of their utility (Hodge 1993). Measuring concrete treatment goals and functional health status using systemic–cognitive–behavioural models seems a more useful approach in the mental health field than older psychoanalytic concepts (Campbell & Cairns 1994).

2. Information processing and cognition

Information technology allows data to be transferred, manipulated, and transformed into graphical information which facilitates interpretation (Drucker 1988; Mazur & Hickam 1993). Once processed by statistical techniques and organised in meaningful ways, the information must be considered by clinicians. Group processing structures in the service include clinical review meetings,

continuous quality improvement teams, research groups, team reviews and service utilisation reviews. To be open to learning from feedback, individuals participating in such structures must adopt a curious and non-defensive attitude (Argyris 1991). Useful practices include rigorously differentiating between observations and theories, and seeing knowledge as heuristic, rather than truth. During the project, dialogue about workloads and work practices has facilitated group learning and enabled change, but these processes require time, which is costly, and are best focused on major organisational matters.

3. Planning and coordinated action

Successful services must actively seek opportunities for improvement in clinical practice, and be prepared to re-engineer work processes and retrain staff if new methods of intervention seem more effective (Newton & Wilkinson 1994; Porter-O'Grady 1996; Quinn, Anderson & Finkelstein 1996). Effective group decision-taking, commitment to decisions taken, and receptiveness to re-skilling, are essential for rapid change in any of these areas. Some authors have observed that managing professionals is like trying to herd cats, but harder (Chowanec 1994). Learning organisation theorists, however, argue that staff do not require control if they are clear about what is required, hold themselves accountable to the team, and seek feedback about the results of their actions (Senge et al. 1994). Commitment and motivation are enhanced by feeling one is a part of a worthwhile organisation and contributing to a team (Kinston 1983; Newton & Wilkinson 1994). They are further enhanced by the experience of being part of a group mind, where dialogue occurs regularly and involves members in a deep conversation (Zemke 1996).

Discussion

During 1996 and into 1997, Maroondah CAMHS has taken several developmental steps towards becoming a learning organisation. The organisational change literature emphasises such issues as structure, vision, work process re-engineering, planning, accountability processes and leadership. It rarely considers how culture is built, and how structure and culture can be aligned so that the parts operate in synchrony. It is self-evident that to function optimally, units must relate to the whole in a coherent manner or be connected naturally and logically, and the individuals in those units must understand and accept how they can make the whole work better. The system is more likely to move in the same direction when the actions of organisational members are focused by a shared vision of what is required and are driven by joint commitment to a common course of action.

The processes of cooperative change described occurred in three small work units (20–30 individuals) of well-educated or professional staff, in an organisation which had relative autonomy in designing its work. They might be applicable to units within a larger hospital, perhaps business units or divisions responsible for product lines, provided interdisciplinary rivalries or tensions were not institutionalised. However, they are consistent with the claims of recent authors on learning organisations (for example, Senge 1990; Jones & Hendry 1992; McGill, Slocum & Lei 1992; Garvin 1993; Schein 1993; Bennett & O'Brien 1994; Senge et al. 1994; Nevis, Di Bella & Gould 1995; Schneider, Brief & Guzzo 1996). The positive tone of this report is based on preliminary experience, and there is little quantitative data on the extent to which these changes and experiments have actually improved service efficiency or effectiveness. However, there has been significant movement towards realising the goals described earlier, and more closely matching the descriptions of a learning organisation provided in Tables 1 and 2.

For example, new workload benchmarks have increased output; outcome measures are now being trialed in the routine clinical practice of the service; a patient satisfaction study has established a baseline for quality improvement; clinicians receive monthly feedback about workload activity and throughput; automatic clinical review processes have been established; the practice of group dialogue has identified several strategic dilemmas for the service, and improved organisational decision-taking; the service has received significant external research grants; students are enjoying placements there; and, despite obvious stress at times, there is evidence of involvement and playfulness in team meetings. The practice of dialogue and sharing experience with an attitude of curiosity and humility has enhanced partnership, trust and commitment to the teams (Senge et al. 1994), and the implementation of team decisions (Schein 1993). This is consistent with modern anthropological views which see the self as a point of view that unifies the flow of experience into a coherent narrative (Bruner 1986), which is necessarily embedded in culture and community.

To participate in a working partnership to co-create a learning community has required giving up control to risk outcomes which were not fully predictable (Block 1993). It has also involved tolerating feelings of incompetence while learning new skills to engage in deeper discussions and dialogue (Senge et al. 1994). The dialogue experiences developed surprisingly quickly in this setting, enhancing group understandings of complex matters, including gender and inter-professional issues, and building more direct communication which, in turn, contributed to making dialogue easier – a virtuous circle. Instead of creating 'group think' where people's views did not differ, it has had the contrary effect of promoting expression of a wide range of views, as there was little

defensiveness around hierarchy. By combining dialogue with discussion about strategy, management group members with interdependent folios have produced complex interlocking decisions and action plans. In effect they became the 'business brain' of the service (Garratt 1987).

McGill and colleagues (1992) describe how generative learning about work processes in production industries depends on management practices which reflect openness, systemic thinking, creativity, a sense of efficacy, and empathy. This description, like that of Senge (1990), emphasises that leaders need to reduce control while also providing direction and confronting systemic performance problems. In the current project this was achieved through establishing a partnership with the management group, providing direction (through creating the vision and the strategy), and changing the structures to make them more appropriate for the work task. Skills in building partnerships are a major part of developing new learning cultures, and generic health management can only be successful through creating working partnerships with clinicians who understand the work task.

Conclusions

Mental health organisations need to redesign themselves to create synergy between individuals and groups in producing outputs which include learning. This requires cultures which involve staff, enhance communication, encourage experimentation and challenge ideas. By appealing to shared values, orienting individuals to a common vision and understanding of their relationship with the environment, defining standards and goals with their work teams, and making the results of their actions more visible, team members become more accountable for their actions and work together more effectively. The learning organisation model promotes communication and curiosity, an interest in outcomes and measurement, and supports the personal development of their members. The current climate requires an orientation to efficiency, to establishing partnerships with clients, and to embracing the culture of continuous improvement. The model does all of these and seems to be highly appropriate for a mental health service.

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