When knowing the answer is only half the solution: Introducing changes to a mental health rehabilitation service

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Abstract

An Action Research methodology was used to revise the St George Mental Health Rehabilitation Service. A review committee found several limitations in the existing system, and a new model to address these problems was devised. During an 18-month period, the new model was implemented. Obstacles to change, such as staff resistance, were not systematically encountered due to the method of change used. The organisational changes that emerged concurrently improved the standard of service, raised staff morale, resulted in the routine use of standardised client outcome measures, enhanced the professional status of rehabilitation workers and led to empowerment of staff and consumers.

Introduction and literature review

Organisational change, despite its intentions for improvement, often poses a threat to staff at the 'grass roots level' (Hart & Bond 1995). Resistance by staff has the potential to obstruct progress, preventing beneficial changes from taking place. Therefore, it is necessary for the management group to plan such changes with care.

The present study utilises the Action Research methodology to implement a modified mental health rehabilitation program. This method of instituting

organisational change, originally developed by Lewin (1947), relies on a process of collaboration between researchers, employees and managers (Hart & Bond 1995). Participants in the organisation work together to evaluate the existing service and to develop a new service delivery model (Prideaux 1990; Rogers & Palmer-Erbs 1994; Hart & Bond 1995; Hart 1996).

The unique method of applying *research* simultaneously with *action* gives participating staff the opportunity to evaluate and modify any proposed changes. This ensures that the new procedures will work effectively in the daily work setting. In addition, the active role given to staff reduces the likelihood that they will hinder attempts made to advance service delivery (Rogers & Palmer-Erbs 1994; Hart & Bond 1995). Action Research methodology has been effective in driving organisational change in the St George Mental Health Service, where one of the initial projects using this method to facilitate organisational change in the service analysed the service responsiveness to client needs during acute admissions (Tobin, Dakos & Urbanc 1997).

There are four types or phases of Action Research described by Hart and Bond (1995). These are experimental, organisational, professionalising and empowering. This nomenclature provides a useful framework for analysing the change process that occurred in the St George Mental Health Rehabilitation Service.

The St George Mental Health Rehabilitation Service was identified as in need of change because of increasing concerns that the existing program was not meeting the rehabilitation needs of clients. The program appeared to be focusing on the provision of recreational and social support group programs for those clients who were well enough to attend a centre-based program. By contrast, an efficient and adequate rehabilitation service should be designed to address the specific individual disabilities of clients resulting from mental illness, and to improve their everyday social functioning (Farkas, Cohen & Numec 1988).

Such programs should consist of individual client assessment and goal setting, followed by individual and group programs which are aimed at enhancing social, communication, domestic, leisure, vocational and self-care skills (Farkas, Cohen & Numec 1988). These may contain individual elements of symptom/stress management, problem-solving and community awareness, family education and support, and liaison with community organisations, but these must be provided according to individual client need, and not on the basis of staff interest or skill.

The organisational context

The Division of Psychiatry and Mental Health is part of the St George Hospital and Community Health Service, which services a population of 220 000 people in an outer suburban area of metropolitan Sydney, Australia. The St George mental health program comprises an inpatient unit, which is administratively and financially integrated with two community mental health teams (comprising multidisciplinary case managers) and a 24-hour crisis team. Prior to 1995, the rehabilitation service was separated geographically from the rest of the community mental health program and functioned semi-autonomously as a drop-in centre providing some group activities. It was recognised that the introduction of any new system to the organisation would be a major task. In expectation of the likely obstacles, a collaborative approach was taken to initiate changes.

Change methodology

Evaluation of the existing service

The first step towards change was to establish a rehabilitation review committee, which reviewed the mental health rehabilitation program by evaluating current rehabilitation practice and comparing it with a best practice framework.

The evaluation occurred via structured group discussions with clients of the program and with the local Mental Health Consumer Consultative Committee (comprising mental health consumers and carers). The staff of the rehabilitation service were involved as facilitators in these group discussions and were assisted by the Area Mental Health Rehabilitation Coordinator.

The review found significant inadequacies with the current rehabilitation service, including the following.

1. Poor integration of acute psychiatric treatment with the rehabilitation program.
2. Relative neglect of more severely disabled clients who did not have the skills or resources to attend the centre.
3. Little involvement by clients and carers in setting rehabilitation goals.
4. Lack of systematic evaluation of the program.
5. Low morale amongst rehabilitation staff which was associated with a low sense of achievement.
6. Relative absence of specialised rehabilitation skills among the rehabilitation staff.

Developing a new theoretical model

The committee not only assessed aspects of the existing program; it also investigated positive features of other rehabilitation systems that appeared to conform to the principles of best practice. This involved a review of the mental health rehabilitation literature and visits to other mental health rehabilitation services in New South Wales. These activities engaged rehabilitation staff in understanding what might be possible in the change process.

Following the reviews, an outline of an alternative effective rehabilitation program was developed. This contained the elements of an ideal rehabilitation service and the specific staff skills that would be required to implement it. At all times, staff were reassured that they would be an integral part of the new model and that training would be provided to enhance their skills as required. Thus the proposed new model was collaboratively developed.

Description of the new service model

The new service model comprised the following elements.

1. Referrals were encouraged from clients who had disabilities which interfered with their role functioning (as assessed by their mental health case manager or by themselves).
2. Each client referred would receive a structured rehabilitation assessment and an intervention plan in collaboration with the staff, the client and a carer.
3. The intervention plan would be specified in objective terms, be limited to three to six months, be aimed at measurable improvements in role functioning, and would occur as far as possible within the client's own environment.
4. Outcome measures would be performed at three regular intervals including the point of entry, and three and six months during the treatment phase. The outcome measures chosen were the Life Skills Profile (Rosen, Hadzi-Pavlovic & Parker 1989), Role Functioning Scale (McPheeters 1984) and Family Burden Scale (Paykel et al. 1982). All outcome measures were relatively simple to use and were familiar to a majority of staff.
5. The rehabilitation plan would be coordinated with any ongoing treatment; and this coordination was made the responsibility of the treating team. Each multidisciplinary treating team had a rehabilitation staff member assigned to it, thus establishing a matrix structure for client care. Clients of the former system, as well as graduating clients of the new system, were facilitated to use non-mental health social and recreational facilities with time-limited assistance from one member of the former rehabilitation service.

Managing anticipated problems

There were three anticipated problems.

Staff unwillingness to change

This phenomenon is commonly described in management texts (Prideaux 1990; Simmerman 1994; Vestal, Fralicx & Spreier 1997). Measures that were introduced to reduce this resistance included:

1. Ensuring that staff were able to express their value systems, such as the desire for a high quality service.
2. Communicating that the project was a high priority with unequivocal management support.
3. Commencing the project on a small scale, using only interested staff (thus not expending energy trying to engage more resistant staff at the early fragile stage of the project).
4. Providing a small amount of pilot project funding.

Consumer resistance to change

The second source of anticipated difficulty was resistance to change from the broad group of consumers who were using the existing rehabilitation service. These included clients, carers and non-health agencies (government and non-government) which regularly made referrals. Since they were frequent current users of the service, it was felt to be unlikely that they would see much need for change. The proposed beneficiaries of the new service were not yet engaged and hence could not be expected to support the system. To deal with this potential problem, all of these groups, including non-users of the former system, were invited to engage in the development of a St George District Mental Health Rehabilitation Strategic Plan. This allowed their participation in developing some details of the new model, set the model in a broader organisational context, and provided a forum whereby the management group could explain and justify implementation, on the basis of serious unmet needs.

Staff skill deficit

The third anticipated problem was that staff were likely to lack the necessary skills to implement the new model since they had been providing a different type of service for some years. Regular staff education and training sessions were scheduled to overcome this problem. The topics covered within this staff development program included motivating 'unmotivated' clients, establishing

rapport, individual goal setting in collaboration with clients, establishing and maintaining community contacts to provide mainstream activities after rehabilitation, and the routine use of client outcome measures.

Managing unanticipated problems

Concerns raised

Whilst many problems could be anticipated, it was recognised that all such change projects would result in unexpected difficulties. Therefore, monthly 'action research' meetings of all rehabilitation staff were scheduled to address such difficulties as they emerged. At these meetings, staff were encouraged to share their experiences with the new model, to identify problems and suggest solutions. These meetings also served to increase commitment of staff by involving them in the adjustments necessary to make the model workable in real clinical practice. Typical issues raised at such meetings included:

1. Lack of clarity of goals of new rehabilitation service compared to existing case management.
2. A perceived low profile of rehabilitation.
3. The need to interest case managers in rehabilitation in order to encourage suitable referrals.
4. The appropriate management of time commitments as better skilled staff had to provide support to, and supervision of, less experienced staff as they gradually came on board with the new program.
5. The lack of evaluation skills amongst rehabilitation staff, resulting in difficulties in implementing routine outcome measurement.
6. Ensuring that consumers of the former service continued to have their needs met, albeit by other sources.

Action Research process

In the process of discussing difficulties, it became apparent that unless concerns (even seemingly minor ones) were promptly addressed they had the potential to derail the project. For example, some case managers wanted to deny rehabilitation staff access to client medical records. Rapid resolution of this issue was essential, as the new model required a close collaboration between rehabilitation staff and case managers in order to avoid duplication of services. Prior to discussion of the issue at the monthly meeting, rehabilitation staff had resolved to develop their own client case file. During the meeting this solution

came to be seen as counterproductive to the model and hence the idea was abandoned in favour of organisational policy changes which ensured that client files became service-based rather than provider-based.

Within the monthly 'action research' meetings, the effectiveness of the new model was continuously being assessed as staff presented examples of individual rehabilitation programs they were developing with clients, and described their difficulties. The proposed interventions were the subject of critical appraisal by other staff and, where appropriate, suggestions for modifications were made, and these were then discussed with the client. More importantly, minor changes to how the new model was being implemented were continuously made as a result of these ongoing evaluations. Using such a process of evaluation and modification, systematic resistance to organisational change amongst staff was overcome. The complete cycle of change from initial evaluation of the former system to the completion of implementation of the new model took 18 months.

Evaluation of the process

Staff views

The views from the case management teams and those of rehabilitation providers were sought at regular intervals. Whilst initially most mental health staff were skeptical of the changes, they had become satisfied with the new model within 12 months. This was evidenced by the strength of their requests for additional staff to be allocated to the rehabilitation program and by an increase in the number of referrals to the program.

Consumer views

Consumer satisfaction with the new model was assessed formally on two occasions using two focus groups of clients who had received at least three months of service in the new model. The discourse was audio-taped and subjected to content analysis. Results were disseminated to the participating staff and became part of the ongoing 'action research' meetings.

Feedback was also sought from the Consumer Consultative Committee, the Mental Health Rehabilitation Strategic Planning Committee, and from individual consumers in an informal way. Consumer feedback led to some changes in the model, including the introduction of community integration with mainstream activities for improved clients.

Client clinical outcomes

Individual client progress within the new program was assessed in a more systematic way using the cumulative results from the standardised instruments. A review of the first 100 clients using Life Skills Profile scores at entry to the program showed high levels of disorganisation and low levels of motivation. This confirmed that the new program was targeting the required disadvantaged group. These results are currently being analysed in greater detail and will be reported elsewhere. It was notable that the new service achieved full compliance with routine outcome measurement, compared with the previous activity-focused service model.

Organisational system changes

Several organisational changes occurred as a result of this project. These included improved collaboration between clinical case management and rehabilitation services. The problems of duplication of services or the neglect of a rehabilitation component of clinical service were overcome with the implementation of a streamlined referral process and a coordinated clinical plan. An unexpected impact of the new collaboration was that clinical case managers learnt new behavioural intervention skills from rehabilitation staff, and these were applied in their routine clinical practice. Similarly, rehabilitation workers gained a better understanding of the treatment issues that could impact on the rehabilitation process. The process also stimulated an ongoing commitment to collaborative service planning and development. A large number of clients, carers and staff remained involved in the rehabilitation strategic planning process and other subsequent change activities.

Long-term evaluation

A review of the program was conducted one year following full implementation of the new model. It was seen to be well established, staff were undertaking routine measurement of client outcome, and the 'action research' groups were still in place and were being used continually to refine the service. One of the more recent refinements has been an examination of how to extend the model being provided to a multicultural context.

Discussion

In this project organisational change was successfully introduced using an Action Research methodology. Beneficial changes to the rehabilitation program were made through the cyclical process of evaluation, analysis, planning, intervention and repeat evaluation. In the present study, difficulties due to staff resistance were largely avoided by consistently involving clinicians in every step of the change process.

Professionalisation

The professionalising phase in Action Research refers to changes that are aimed at raising the professional status of an occupation by developing work practices that are based on a foundation of research (Hart & Bond 1995). Such professionalisation has occurred in this project, specifically, with the routine collection of clinical outcome data, which will be used subsequently for further mental health rehabilitation research. Professionalisation can also be said to have occurred by the improved profile of rehabilitation services within the mental health system, and by the systematic staff skill development process which was put in place.

Empowerment

The project can also be seen to demonstrate the empowering type of Action Research, which has a focus on changing the balance of power in favour of formerly less powerful groups (Hart & Bond 1995). Within the project, empowerment occurred by means of involving staff and consumers in decisions about problem definition and solution generation. Staff at the 'grass roots level' were able to share responsibility for, and ownership and control over, organisational change.

Experimentation and organisational change

This project demonstrated that inquiry, data collection and analysis, and system response became aspects of one organisational change process rather than separate and sequential activities. This reduced staff perception that research was being 'done to them' which was a problem found in a former change project (Tobin, Dakos & Urbanc 1997).

Disadvantages of the model of change

This model of organisational change is not necessarily suitable for change in every setting. As can be seen from the fact that the new model of rehabilitation took 18 months to implement, it certainly has the disadvantage of complicating and lengthening the change process. Furthermore, involvement of persons from different backgrounds and perspectives may make it difficult to reach any agreement about a new model. The utility of the approach with this particular project lay in the need for cultural and major systemic change rather than in any need for rapid solutions to urgent problems, where alternative change strategies may be more appropriate. In addition, as with all new initiatives there is a potential danger that reforms may become institutionalised and the organisation risks entering a new stagnation stage. Hence it is crucial that the organisation maintain an action learning focus to provide structural support for future growth and organisational development (Tobin, Dakos & Urbanc 1997).

Conclusion

It is evident from this study that management need not autocratically impose effective organisational change. The slow and evolving method of Action Research can deliver effective improvements to a service and the effects may be more enduring than when less participatory methods are used. Organisational growth can also have the benefits of professionalising and empowering staff, thereby improving staff morale; and of creating a sustainable culture for the inclusion of consumer viewpoints into system developments.

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