Building Capacity in Non-government Alcohol and Drug Services

The Queensland Experience

Acknowledgements

This project was undertaken for the QLD Network of Alcohol and Drug Agencies (QNADA) by Dr Leanne Craze and Adjunct Professor John Mendoza from ConNetica Consulting. The QNADA CEO, Ms Margi O'Connell Hood was the Project Manager.

Eleven QNADA member agencies participated in the research and without the willingness of the Improved Service Initiative Coordinators and the Chief Executives of all the agencies to share their story of cultural change then the project would not have been possible.

This Research Project was made possible through funding from the Department of Health and Ageing.

The ISI is a rare project and DOHA is to be congratulated for having the foresight to design a project like this. It gave us the resources and enough flexibility to do what made sense here in this service, in our local areas and with the needs of our client group. The project has made a significant difference to client outcomes. The project has saved the government money because many people with complex needs related to co-morbidity are now being assisted as against being excluded or banned from services.

An ISI Project Coordinator

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Glossary of Abbreviations

AOD	Alcohol and other Drugs (sector)
CAMHS	Child and Adolescent Mental Health Services
BLS	Baseline Study
CBT	Cognitive Behavioural Therapy
CSSSP	Cross Sectoral Support and Strategic Partnership
COAG	Council of Australian Governments
DBT	Dialectic Behavioural Therapy
DDCAT	Dual Diagnosis Capability in Addiction Treatment Index
DOHA	Department of Health and Ageing
ISI	Improved Services Initiative
MBS	Medical Benefits Scheme
NGO	Non-Government Organisation
QIC	Quality Improvement Certificate
QNADA	Queensland Network of Alcohol and Other Drug Agencies
PBS	Pharmaceutical Benefits Scheme
PsyCheck	A mental health screening tool
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RTO	Registered Training Organisation

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President's Foreword

It is with pleasure that I write the foreword to this publication. For QNADA, this is our first publication and a further commitment to evidence-based practice with our capacity to support the alcohol and drug sector.

During the three years covered in this report, QNADA has supported participating services through networking, information dissemination, representation in government forums as a single voice and providing an ear to workers when times were difficult. QNADA has also forged links with the mental health sector and other community service peaks to increase the overall understanding of the complex needs of people with mental health and substance abuse comorbidity.

We were very fortunate to have ConNetica conduct the research on our behalf. John Mendoza, Principal of ConNetica, has a national profile in both the mental health and alcohol and other drugs sectors. Leanne Craze, ConNetica Senior Consultant is well regarded for her work in the Mental Health field. Leanne was nominated this year for an Achievement Award at the national Mental Health Services Conference. Their knowledge of the challenges faced by the services in achieving the need for cultural change within their organisations greatly enhanced the outcomes of this research.

Looking back over the past three years, as I read this work, I realised how momentous the changes were for participating organisations, including DRUG ARM Australasia. DRUG ARM is a participant in the Improved Services Program that has greatly enhanced the charity's ability to deliver quality alcohol and other drug education, treatment and outreach services to the community.

Fortunately, QNADA has captured much of the tools and resources developed by these services and by other organisations researching and developing mental health and drug and alcohol co-morbidity. This work, along with the stories recounted here, will make the transition to being capable of addressing co-morbidity much easier for other services in the sector.

I congratulate the organisations that participated, and the team of researchers for their contributions to this work. I thank the Treatment Programs and Policy Section of the Department of Health and Ageing for their funding and support.

Dr. Dennis Young

President,
QNADA

The Research Team

John Mendoza

Director, ConNetica Consulting

John is a Director of ConNetica after a career that has seen him hold several executive positions including the inaugural Chair of the Australian Government's National Advisory Council on Mental Health, CEO of the Mental Health Council of Australia and CEO of the Australian Sports Drug Agency. John's professional appointments, include

- Adjunct Professor, Faculty of Health and Sport Science, University of the Sunshine Coast
- Adjunct Associate Professor, Faculty of Medicine, University of Sydney
- Board member of the new $27m Cooperative Research Centre: Young people, Technology and Well-being

John has authored and co-authored dozens of reports and submissions to public inquiries on mental health and suicide in the past six years. He is widely credited with having played a critical role with Professors Pat McGorry and Ian Hickie, in securing the $2.2billion mental health reform package in the 2011 Federal Budget. In 2005-6, he also played a key role in development and implementation of the campaign advocacy to secure the $5billion under the COAG Mental Health Plan.

John has had a long involvement in the alcohol and drug field. Previously in the 1980s he was Director of Education with the Drug and Alcohol Services Council of SA and a member of the National Steering Committee for the National Campaign Against Drug Abuse (NCADA) and later a lecturer in Public Health at Queensland University of Technology before taking up his appointment as Deputy CEO with ASDA in the mid-1990s.

Leanne Craze

Researcher, ConNetica Consulting

Leanne Craze, with a PhD (UNSW, Faculty Professional Studies) and Bachelor Social Work Hons 1 has held academic positions in social work at the University of Western Sydney and the Australian Catholic University. Leanne has also held a number of senior positions including: Principal Researcher, Victorian Parliament Social Development Committee Inquiry into Mental Disturbance and Community Safety, Secretary, Joint Parliamentary Committee on the National Crime Authority, Australian Senate and Senior Criminologist, Australian Institute of Criminology.

Leanne's reputation in providing sound research and project management to large-scale and complex national and state-based initiatives is evident by her having been awarded the following consultancies for example:

- The Conduct of the Australia-wide consultations to recommend on a national peak body for the mental health sector (ie Mental Health Council of Australia);
- Community Involvement Project in Australia and New Zealand2003, (with Australian Mental Health Consumer Network), Royal Australian and New Zealand College of Psychiatry; and
- Conduct of the Australia-wide consultations on the establishment of a new Mental Health Consumer Peak Body (Scoping Project) 2009-2010.

Leanne has also worked closely with a wide range of community and consumer groups, non-government services, community sector organisations and industry groups.

Leanne, in her role as Secretary to the Human Rights and Equal Opportunity Commission's Inquiry concerning the Human Rights of people with Mental Illness was able to contribute toward the formulation of the Commission's recommendations for reform. Her knowledge of mental health law enabled Leanne to work with a group of legal academics to draft the National Model Mental Health Laws. This significant piece of work has been used as a benchmark ever since by Australian jurisdictions when reforming their mental health statutes. Leanne's PhD thesis, the Care and Control of Mentally Ill Offenders in NSW, provided a blue print for legislation and service reform for mentally ill offenders. A significant change that has now been made that was hitherto thought impossible is the removal of executive discretion in disposition and release decisions. Leanne's research in this area led to the establishment of the NSW Mental Health Advocacy Service and has aided the critique of policies and practices underpinning assessments of dangerousness.

Leanne's work was recently recognised when she was awarded the Australian and New Zealand Mental health Services Exceptional Contribution Award in '*In recognition of substantial roles taken in shaping the future of Mental Health services and in addressing emerging issues, demonstrating true expertise and creativity in contributions to research, advocacy, reform and consultancy, underpinned by resolute support for the rightful place of the consumer voice.*

Executive Summary

'it was a tough but perfect confluence .....'

Introduction

Mental illness and drug and alcohol misuse related conditions often go hand-in-hand and require integrated and recovery-based treatment approaches of both disorders. Australian research in 2004 showed that almost two in five people who used an illicit drug experienced high or very high levels of psychological distress.

In response to this and the well documented difficulties in developing more integrated and effective services, the Commonwealth Government provided funded for the Improved Services Initiative within the *Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011*.

The *Improved Services Initiative* (ISI) built on the *National Comorbidity Initiative* and specifically focused on building the capacity of non-government drug and alcohol treatment services to provide best-practice services that effectively identify and treat coinciding mental illness and substance abuse. The 2006-2007 Australian Government Budget provide $73.9 million over the five-year period for the ISI program. Of this $67.7 million was allocated for the building of capacity in Alcohol and Other Drug Non-government treatment services to better identify and respond to people with drug and alcohol and mental illness (*ISI Capacity Building Grants Program*).

National Capacity Building Grants

Non-government drug and alcohol treatment services across Australia were funded by the Australian Government Department of Health and Ageing (DOHA) through a competitive grants process to undertake a range of capacity building activities including organisational cultural change, workforce training, developing partnerships with local area health services and developing and implementing policies and procedures that support the identification and management of clients experiencing coinciding drug and alcohol problems and mental illness. The funding available was significant, with grants of up to $500,000 over a three-year period being awarded.

Eleven Queensland agencies were awarded ISI Capacity Building Grants.

QNADA and its fellow non-government drug and alcohol peak bodies (or their equivalent) in each state and territory were provided additional funding to support the successful ISI organisations through the *Cross Sectoral Support and Strategic Partnership Project* to coordinate a state-wide approach to the project.

The Cultural Change Research Project

ConNetica Consulting, on behalf of QNADA, conducted this research project as part of the *Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative* (ISI) in Queensland. The research project became known as the Cultural Change Research Project. The project commenced March 2011 and concluded in early June 2011.

The aims of this research project were two-fold. The first aim was to document the processes of cultural change that had evolved during the program. The second aim was to use the findings and lessons learned to develop cultural change tools and resources to assist the drug and alcohol sector in Queensland as it undertakes further cultural change in the future.

The Cultural Change Research Project methodology comprised three phases: Pre-research and development of the research tool; Interviewing and data analysis; and Preparation of the research report. The questionnaire was conducted onsite with the Project Coordinators of each funded ISI agency. Interviews were in-depth and were usually three hours in duration.

The cultural change journey of the ISI funded agencies

From the outset, the eleven alcohol and drug organisations in Queensland funded through the National Comorbidity Improved Services Initiative understood that this was not going to be an easy project. The importance of organisational cultural change to improving services for people with alcohol and drug and mental health comorbidity was realised at an early stage. This report documents the cultural change journey undertaken by agencies and details their struggles, their wins and losses, and how a range of key factors combined to create both an imperative for and awareness of the need for change.

As such the report outlines how undertaking the project was experienced as '*a tough but perfect confluence'* by the funded agencies in Queensland. The report also details strategies and resources developed, lessons learned and the suggestions of agencies for future cultural change initiatives in Queensland.

Identifying the cultural change required

An initial task for agencies was to identify what needed to change in their culture and what they wanted their culture to change to. The directions for culture change identified by agencies included:

- Becoming specialists with complexity;
- Regaining relevancy to the lives of clients;
- Becoming specialists in comorbidity;
- Becoming a leading partner in a local network of services for people with comorbidity;
- Being a 'no wrong door';
- Becoming a provider of a highly regarded suite of services treatment and programs for people with comorbidity;
- Being culturally inclusive, outward looking and ever reaching out to new client groups;

- Becoming recognised as a provider of a revitalised, contemporary and evidence-based model of therapeutic community; and
- Becoming an alcohol and drug agency that steps over the 'psychosis line in the sand'.

Major contributions to cultural change

Some of the major contributions to culture change evident in the reflections of agencies included:

- Greater professionalism and an up-skilled workforce – a culture that values professional development and strives for improved practice;
- Improved and expanded services – a culture not afraid of change and development;
- Improved and expanded partnerships – an outward looking, more flexible and collaborative culture;
- Improved client outcomes – a culture inclusive of comorbidity and complex needs.

A schema of observed cultural change pathways

Upon reflecting on the Project Coordinator's accounts of the ups and downs and twists and turns of change in their organisations, and drawing on a number of theoretical approaches, the following schema of pathways is proposed:

- Watershed Pathway;
- Empirical and Structural Pathway;
- A Hearts and Minds Practice-Centred Pathway;
- A Community-based and Partnership Centred Pathway;
- A Cultural Change 'Creep' Pathway.

Elements common to the observed pathways for cultural change included:

- Board and management endorsement of the Baseline Study and the need for cultural change;
- The intertwining of the ISI project with quality improvement accreditation processes;
- Staff training and up-skilling;
- The embedding and weaving of comorbidity in corporate documentation;
- Attaining a critical mass of support internally and/or externally;
- Significant improvements in assessment, treatment planning, care coordinator processes and new client information systems; and
- Significant service improvements.

Differences included the level of emphasis given to partnerships, community involvement, staff and client participation, the relative balance struck between top down and bottom up approaches and the level of reliance on data and information derived from benchmarking, auditing and evaluation.

No single approach or pathway dominated. Rather it appears that the pathways differed according to traditions within each organisation, project phases, the aspects of cultural change being pursued and the different tasks being undertaken. It is possible that aspects of each of the described pathways were operating in each agency at different points throughout the project.

Cultural Change Resource Inventories

A series of resource inventories were developed from the wealth of information provided by agencies about the processes, tools and resources they used to achieve cultural change. Each resource inventory identifies an important frame or action area critical to cultural change. The inventories are by no means complete and the research team suggests that QNADA and the ISI funded agencies continue to develop and populate the inventories in the coming year.

What worked well

Strategies that were observed to have worked well during the project included:

- The provision of extensive opportunities for training and improved practice skills;
- Staff involvement in the change;
- Linking change to the familiar;
- Client involvement and guidance;
- A focus on improved outcomes;
- ISI agencies coming together to share resources and problem solve; and
- ISI Project Coordinators having both clinical experience and management experience.

Key Enablers of cultural change

Some of the key enablers of cultural change identified by agencies included:

- The ISI and its funding;
- The leadership exhibited by the agency management team;
- Strengthened clinical governance across the agency;
- Multidisciplinary team environment;
- Partnerships with external bodies;
- Open communication with all staff; and
- Engagement of change champions within the agency.

A further important enabler of cultural change was the introduction of new systems and resources that improved safety and quality whilst also making work easier and more rewarding.

Hardest things to change or the most difficult tasks

Some of the hardest things to change according to Project Coordinators included changing attitudes and practices and obtaining support for departing from the way things had always been done. A further difficulty was introducing a number of new systems, tools and programs all at once and getting the pieces to come together.

The three most commonly identified barriers or obstacles identified by agencies were:

- Difficulty in recruiting and retaining a Project Coordinator with the right skill set and experience;
- Releasing staff for training, and funding appropriate staff to backfill positions;
- Problems associated with the funding cycle and the organisation's capacity to spend certain line items within specified timeframes of the cycles.

What didn't work

Though what didn't work differed from agency to agency, some of the most commonly reported items by Project Coordinators included:

- Duplication of effort;
- Agencies not having a mechanism to report to funders, the impact on the organisation of having complex clients and of doing harder work and to have this impact acknowledged by funders;
- Being able to give sufficient priority to building partnerships whilst also managing the internal change processes and project implementation;
- Being able to successfully engage staff of mental health services who were sufficiently senior to make decisions that could make a difference on the ground;
- Being able to develop and sustain a sufficient focus on client participation.

Key turning points

Some of the key turning points identified during the research project included:

- Endorsement by agency management of the Baseline Study's findings, endorsement of ISI project's direction, endorsement of the imperative for change and declaration of confidence in the Project Coordinator;
- The agency's Board affirming comorbidity as core business as reflected and signposted through incorporation of comorbidity into the mission statement of the agency;
- Organisational restructure to reflect role with comorbidity;
- Reconfiguration of the position of Project Coordinator and responsibility for the project's coordination and implementation;
- Linking the ISI project with a co-occurring quality improvement accreditation process; and
- Addressing the risk associated with comorbidity and more complex needs.

Other important turning points included the provision of particular training during which staff became convinced they could work safely and effectively with people with comorbidity. The roll out of Certificate IV training programs throughout the organisations free of charge to all interested staff, was also pivotal.

Sustainability of the change

Many aspects of the cultural change were considered sustainable, having been embedded in the organisation's mission, corporate documentation and processes. Aspects of the change that were considered possibly not to be sustainable include:

- Continuing to work with the same level of complexity without resourcing of clinical governance and clinical leadership;
- The same level of subsidised workforce development opportunities;
- Ongoing training when trained staff leave the agency;
- Retention of staff without parity of wages to the government sector; i.e. "we train staff with great programs, then lose them to higher paid positions"; and
- Resourcing a dedicated focus on partnership building and sustaining.

Taking the lessons learned forward – suggestions for Department of Health and Ageing

There is little doubt based on the results from this research that the ISI Project has hit the mark in terms of enabling AOD agencies to develop a capacity to address the needs of clients with comorbid mental health problems. Moreover, the project has gone beyond the original objectives in that it has transformed the services provided across the agencies and not just those addressing clients with comorbidity.

The funding provided agencies with the capacity to release staff for training and engage in cultural change discussions and develop and/or change systems. The governance of the project was driven with both a clear starting point (thanks to the Baseline Study) and a clear end in mind. The measures associated with the project were focussed on aspects of cultural change – changes in policy, procedures, processes, and workforce skills, attitudes and practices – and not the usual input and output measures so routinely required with government funded projects. The three-year timeframe for the funding, without annual applications for continued funding, was also seen as contributing to the success of the projects. It was very much a case of the Department of Health and Ageing defining the boundaries and the end goal and then letting the NGO agencies get on with the task. The hands-off style of the Department was praised by many of those involved.

The research team would argue that there are few examples nationally or at a state level where the investment by government has yielded such widespread change in the group of funded agencies. The project governance has resulted in a 'leverage effect' on the overall quality of service and capacity of the recipient agencies, and not merely resulted in 'improved services for people with co-morbidity'.

The ISI is a rare project and DOHA is to be congratulated for having the foresight to design a project like this. It gave us the resources and enough flexibility to do what made sense here in this service, in our local areas and with the needs of our client group. The project has made a significant difference to client outcomes. The project has saved the government money because many people with complex needs related to comorbidity are now being assisted as against being excluded or banned from services.

This is an uncommon experience for NGOs generally and therefore one that DOHA and other Commonwealth and State agencies with responsibility for purchasing services or supporting NGOs need to note and build on.

A number of suggestions were made by agencies to support DOHA to take forward lessons learned from this current cultural change project. The major suggestions related to:

- Changes to the tendering process for organisations based in more than one State;
- Having consistent reporting requirements and templates;
- On-the-ground support and contact with project sites;
- Having the Baseline Study and other data collation tools in place from the outset, particularly for novel and innovative programs;
- Annual conference or similar forum to promote networking and shared learning;
- Greater clarity about the role of state peak bodies;
- Capacity to rollover funds within and between funding cycles.
- Agencies also suggested acknowledgement was required of the time it takes to embed cultural change to the point of sustainability.

Taking the lessons learned forward – suggestions for QNADA

A number of suggestions were made by agencies to support QNADA to take forward the lessons learned from this current cultural change project. The major suggestions included:

- Factoring in a six-month development phase prior to the project's commencement on-the-ground in agencies;
- Engagement with the Boards of agencies from the outset;
- Collaborative project planning with the agencies and/or the sector;
- Working with agencies to ensure good project beginnings;
- Sector workforce mapping and training needs analysis to aid planning for future initiatives.

The importance of the ISI project in Queensland

The participating agencies reported that though the ISI project presented many tough challenges they would welcome a further similar initiative in the future. In analysing the reasons for the success of the initiative in supporting cultural change, the agencies pointed to the enabling and flexible nature of the ISI Program.

The ISI project enabled us to consolidate our service developments, redesign some of our service models and programs, increase the evidence base of what we do and improve the administration and infrastructure that sits around service delivery – new and better frameworks, guidelines, tools, electronic client information system etc.

Conclusion

The *Improved Services Initiative* enabled the participating agencies to achieve a significant level of cultural change. In analysing the reasons for the success of the initiative in supporting cultural change, the agencies pointed to the enabling and flexible nature of the ISI Program, and the fact that the program whilst not prescriptive was outcome based and provided some structure and directions. Importantly, the Capacity Building Grants complemented and were able to be used to augment other comorbidity and alcohol and drug treatment services funding.

> *The ISI provided the fuel and oxygen to enable us to develop and improve our services – we knew we had to and we had wanted to but we didn't have the resources to do so.*

Throughout the project the agencies were able to provide extensive opportunities for staff training and up-skilling, to develop an array of new strategic partnerships, assessment tools, case management and care coordination processes/tools and client information systems and to introduce numerous new service models, treatments and programs.

Cultural shifts observed throughout the project included:

- Enhanced professionalism and an up-skilled workforce contributing to a cultural shift placing greater value and priority on professional development and improved practice;
- Improved and expanded services contributing to an organisational culture that was increasingly not afraid of change and development; and
- Improved and expanded partnerships contributing to a culture that was more outward looking, more flexible and more collaborative.

Finally, a cultural shift to be more inclusive of comorbidity and complex needs was achieved which in turn contributed to improved services and better client outcomes.

Recommendations from the ConNetica Research Team

The ConNetica Research Team makes the following three recommendations to QNADA for taking forward the lessons to emerge from the ISI Capacity Building Program.

Recommendation One: A framework for the planning and conduct of future significant funding initiatives

That by drawing on the suggestions made by agencies, QNADA and the participating agencies collaborate to formulate a framework for the planning and conduct of similar cultural change and service development initiatives in the future.

Recommendation Two: Further development of the resource inventories with a view to their distribution and use throughout the sector

That QNADA and the participating agencies collaborate to further develop and populate the resource inventories so that the resources, tools and learning contained therein can be used to inform and support further cultural change and service development throughout the alcohol and other drug sector in Queensland.

Recommendation Three: Communication to DOHA of the importance of the Capacity Building Grants funding model

That QNADA communicate to DOHA this research project's findings concerning the importance of Capacity Building Grants funding model and the project governance and the way in which this enabled and supported cultural change by providing a level of structure and guidance without being prescriptive, by being outcome-based, by providing significant resources over an extended period of time and by the funding program itself being located within a suite of complementary initiatives.

This project has been very good for our agency as we had for some time had a sense of organisational or corporate guilt about the people we were not accepting or not assisting because of the level of their comorbidity. We were aware of the implications for those people as they fell between service silos. We were also aware of the implications of this for families and communities.

Structure of the Report

The report is divided into four key parts:

Part One: Background and Methodology

Part Two: The beginning of the journey

Part Three: Cultural change

Part Four: Learning about achieving and sustaining cultural change

Part One provides the background to the Improved Services Initiative, this Cultural Change Research Project and an outline of the Project methodology.

Part Two describes how the agencies started to come to grips with cultural change, definitions of cultural change, the processes for getting started on cultural change, identifying and articulating what needed to change and what the culture needed to become and finally the challenges encountered by the agencies on their change journey.

Part Three provides an outline of the cultural change pathways undertaken by the agencies drawing on some of the models and frameworks from the literature. It includes the key action areas, outcomes and strategies adopted by the agencies.

A series of *Cultural Change Resource Inventories* are included in Part 3. These provide a resource framework and future resource repository or toolbox for the AOD (and potentially broader NGO sector).

Finally Part Four describes the lessons learned from the ISI project and how significant cultural change can be achieved and sustained in AOD agencies.

Given the largely qualitative approach to the research, throughout the Report there are quotes from the interviews and discussions with Project Coordinators and managers from the eleven agencies. These are shown in red shaded boxes in close proximity to the relevant text.

Part One: Background and Project Methodology

Part one of the report provides the background to the Department of Health and Ageing's *Improved Services Initiative*, this Cultural Change Research Project and an outline of the Project methodology.

The *National Comorbidity Initiative* was an important component of the *Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011* with $73.9million provided to support the initiative. The National Capacity Building Grants formed the key element of the program.

Non-government drug and alcohol peak bodies (or their equivalent) in each state and territory were funded to support the ISI funded organisations through the *Cross Sectoral Support and Strategic Partnership Project* to coordinate a statewide approach to the project. QNADA, the Queensland peak body, supported the eleven Queensland funded services as they undertook their capacity building projects. Capturing the learning from these projects was a key goal for QNADA.

The Cultural Change Research Project drew on the Baseline Study completed in the early months of the ISI Project. The Baseline Study, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) self-assessment process, a cultural change questionnaire, in-depth interviews and document reviews informed the study.

Background

The knowledge that substance abuse disorders often co-exist in clients with mental illness is not new[1]. Substance abuse may trigger or pre-dispose a person to some mental illnesses (bi-polar, other psychoses) and a number of mental illnesses may pre-dispose a person to substance use disorders or both disorders could arise through some common mechanisms (genetic and epigenetic)[2] [3]. The literature has recognised that mental illness and drug and alcohol abuse often go hand-in-hand and require treatment of both disorders, yet service reform and integration of mental health and AOD services has remained an elusive reform objective [4].

The reasons for this are well documented and include:

- History – particularly the history of mental health services in Australia;
- Philosophies/approaches – one based on voluntary care and harm minimisation and the other (at times) involuntary care;
- Legislation – all Australian jurisdictions have Mental Health Acts;
- Differing policy and governance frameworks – although these have reflected the need for greater integration in the past five years;
- Two impoverished, stressed systems;
- Workforce skills gaps – included in the different screening tools and treatment interventions;
- The perceived limited success or value by clinicians of working with clients with dual diagnosis.

Understanding Co-Morbidity

Over the past decade an increasing body of evidence has been developed surrounding co-morbidity. Co-morbidity in clinical settings is common with rates ranging from 10-90% reported by a number of Australian researchers.

It is clear that individuals with mental illness and substance use disorders experience more problematic outcomes across both clinical and psychosocial domains than those people with either mental illness or substance use disorder. It has been frequently reported that people with co-morbidity are shifted on by mental health or AOD services that see the need for the other service to treat the condition before they can respond.

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1 Regier, DA, Farmer, ME, Rae DS et al (1990). *Comorbidity of mental disorders with alcohol and other drug abuse: results ECA study*. JAMA, 264, 2511-2518.

2 Swann, A (2009), *The strong relationship between bipolar and substance use disorder.* Annals of the New York Academy of Sciences, 1187 276-293.

3 Psycheck: a mental health assessment tool for AOD clinicians

4 Mental Health Council of Australia (2005). *Not for Service: experiences of injustice and despair in mental health services in Australia*. Canberra.

Those who live with both mental illness and substance use disorders are at a greater risk than those with a single diagnosis of poorer outcomes and contribute to higher treatment costs[5].

The use of illicit substances has a direct negative effect on the symptoms of mental illnesses as well as increasing the risk of serious physical health issues such as Hepatitis C and HIV/AIDS. Dual diagnosis clients are also more likely to be homeless, be unemployed, be involved with the criminal justice system, have higher rates of suicide and self-harm and live in poverty when compared with individuals with mental health disorders alone.

It is widely assumed people with mental illnesses use substances to 'self-medicate' to migrate their symptoms or the effects of medication. One Australian study tested this assumption and found that among people with schizophrenia who used illicit drugs and alcohol, the strongest factor was to deal with the 'negative effect' including boredom, insomnia, depression and anxiety. Other important but less powerful motivations included enhancement factors such as 'to get high', social factors (such as 'because my friends do') and self-medication of positive symptoms (such as hearing voices or mitigation of medication side effects)[6].

The provision of effective services to individuals with co-morbidity has been constrained by a number of factors as stated earlier. This has led to models of care that offered either sequential (i.e. one 'problem,' is dealt with prior to the other) or parallel treatments (i.e. each problem, dealt with at the same time but by different services with little or no care coordination). Fortunately the body of evidence to support integrated or collaborative care approaches has developed and it is now generally acknowledged that this is the best treatment approach. Successful integrated approaches incorporate treatment models or techniques from both mental health (e.g. CBT and DBT) and AOD services (e.g. motivational interviewing)[7].

Despite the evidence supporting integrated treatment, it has remained a challenge for AOD and MH services.

The Improved Services Initiative

The *Improved Services Initiative* was an important component of the *Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011*. The inclusion of the ISI in the Commonwealth Government funded initiatives within the COAG National Action Plan was in direct response to the findings and recommendations of reports from the Mental Health Council of Australia and the Senate[8,9].

The *Improved Services Initiative* (ISI) built on the *National Comorbidity Initiative* and specifically focused on building the capacity of non-government drug and alcohol treatment services to

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5 Minkoff, K (2001), Best Practices: *Developing standards of care for individuals with co-occurring psychiatric and substance use disorders*. Psychiatric Services, 52 , 597-599

6 Spencer, C, Castle, D and Michie, P (2002) Motivations that maintain substance use among individuals with psychotic disorders. Schizophrenia Bulletin, 16, 123-132.

7 Minkoff, K (2007), What is Integration? Parts 1-3. J. of Dual Diagnosis.

8 Mental Health Council of Australia (2005). *Not for Service: experiences of injustice and despair in mental health services in Australia*. Canberra.

9 Senate Select Committee (2006). Mental Health Care in Australia: From Crisis to Community. Canberra

provide best-practice services that effectively identify and treat coinciding mental illness and substance abuse. The 2006-2007 Australian Government Budget provided $73.9 million over the five-year period for the ISI program. Of this, $67.7 million was allocated for the building of capacity in Alcohol and Other Drug non-government treatment services to better identify and respond to people with drug and alcohol and mental illness.

National Capacity Building Grants

Non-government drug and alcohol treatment services across Australia were funded by the Australian Government Department of Health and Ageing through a competitive grants process to undertake a range of capacity building activities including organisational cultural change, workforce training, developing partnerships with local area health services and developing and implementing policies and procedures that support the identification and management of clients experiencing coinciding drug and alcohol problems and mental illness. The funding available was significant with grants of up to $500,000 over a three-year period being awarded.

In Queensland the following eleven agencies were funded:

- Ozcare
- Goldbridge Rehabilitation Services
- Gold Coast Drug Council
- Alcohol and Drug Foundation of Queensland
- The Queensland Aboriginal Torres Strait Islander Corporation for TSIC Alcohol and Drug Dependence Services (QAIS)
- DrugArm Australasia
- Youth Empowered Toward Independence
- Teen Challenge Queensland
- QuIHN
- Brisbane Youth Services
- Lyons House Inc

Between them, the services covered a comprehensive array of service models and organisational types. There were faith-based charities, local community organisations and user support services. One was a national service while another had services in three states. One had services in three sites within Queensland and another had outreach workers across the state. Some were stand-alone alcohol and drug services, some included medical facilities and others a complete array of social services. One specialised in Aboriginal and Torres Strait clients, and a number counted a significant proportion of First Peoples as their clients. Other agencies specialised in young people and some had expertise in working with the homeless and prison populations.

The success of the ISI project across this diverse range of service and organisational types highlights the effectiveness of the funding model in achieving its outcomes in a complex environment. It also indicates that the diversity of the alcohol and drug sector, so essential in providing client choice, need not be an impediment to sector-wide changes in policy.

Other National Comorbidity Initiatives

A total of $8.2 million of the ISI funds were allocated to continue the work of the National Comorbidity Initiative to improve coordination between mental health services and drug treatment services. Relevant initiatives that the Queensland ISI funded agencies availed themselves of included:

- The trial dissemination of *PsyCheck*, a mental health screening tool;
- The development of National Comorbidity Clinical Treatment Guidelines;
- The development and roll out of *Can Do: Managing Mental Health and Substance Use in General Practice*;
- Comorbidity Professional Development Scholarship Program;
- Comorbidity Service Model Evaluation Project; and
- Supporting supervision of post-graduate psychology and social worker placements.

Cross Sectoral Support and Strategic Partnership (CSSSP)

Non-government drug and alcohol peak bodies (or their equivalent) in each state and territory (QNADA in Queensland) were funded to support the successful ISI organisations through the *Cross Sectoral Support and Strategic Partnership Project* to coordinate a statewide approach to the project. QNADA, the Queensland peak body, supported the eleven Queensland funded services as they undertook their capacity building projects.

QNADA as a member of the national network of state peak bodies worked closely with grant recipients to provide support in five key areas:

Objective 1: Build sustainable linkages and strategic partnerships between the AOD NGO sector and other health and community support sectors to support the identification and treatment of comorbidity.

Objective 2: Assist AOD NGO treatment services, particularly Improved Services capacity building grant recipients, to undertake service improvement activities.

Objective 3: Identify and facilitate training opportunities for AOD NGO treatment services, particularly Improved Services capacity building grant recipients.

Objective 4: Provide targeted and relevant information and resources to the AOD NGO treatment sector.

Objective 5: Project Management – Up skilling workforce and development of evaluation tools. The Network was funded for an initial twelve months in January 2008 to participate in the CSSSP project, and received additional funds to work on this for another three years (July 2009-June 2012).

In Queensland a particular focus of QNADA was supporting the ISI funded agencies to undertake organisational and cultural change and development.

Capturing the Learning to Inform Future Change

QNADA was also motivated to capture the findings and document the lessons learned from the Improved Services Initiative to assist the drug and alcohol sector in Queensland as it undertakes further cultural change in the future. This report documents the cultural change journey undertaken by agencies and details their struggles, their wins and losses, and of how a range of key factors combined to create both an imperative for and awareness of the need for change. As such the report outlines how undertaking the project was experienced as 'a tough but perfect confluence' by agencies. The report also details strategies and resources developed, lessons learned and the suggestions of agencies for future cultural change in Queensland.

Important sources of information for the Cultural Change Research Project

The Cultural Change Research Project drew on information contained in the *Baseline Study* (Appendix 1) of each ISI funded agency. The Baseline Study completed in the early months of the ISI project had a number of key purposes including to:

- Help organisations scope the objectives to be achieved under the Improved Service for People with Drug and Alcohol Problems and Mental Illness (Improved Services) Measure in order to develop their Project Plan;
- Provide an initial benchmark against which to measure the success of the Project;
- Help to engage and inform stakeholders in the process of evaluating, planning and implementing the Improved Services Measure to ensure its success.

The Department of Health and Ageing (DOHA) provided a Baseline Study Template that contained a list of questions to help agencies examine their capacity at the start of the project to respond to the needs of people with comorbidity. The questions were not compulsory given all organisations are different and some questions may not be applicable. Nor were the questions a complete list of those that could be asked. The questions were designed as discussion points for developing a shared understanding within an organisation of its current capacity to service comorbid clients and, in the process, to identify objectives for the *Project Plan* in order to improve that capacity. To make the investigation of organisational capacity easier, the questions were grouped under 10 headings common to policies and procedures manuals for non-government organisations.

1. Eligibility
2. Access
3. Organisational Culture
4. Client Assessment
5. Client Services
6. Client Participation
7. Case coordination and referral
8. Personnel Support, Development and Retention
9. Physical Assets
10. Research and Development

Each of the eleven Queensland ISI funded projects shared their Baseline Study with the ConNetica Research Team. The information contained in the Baseline Studies contained a wealth of information that enabled the agencies and the Research Team to reflect upon and

analyse cultural change that had occurred throughout the capacity building projects. The structure and content of the Baseline Study Template also informed the development of the Cultural Change Questionnaire developed for this research project. (Appendix 3)

The *Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index* was a further source of information drawn on by agencies as a validated tool to assess the service's capacity to meet the needs of clients with dual diagnosis in drug and alcohol services. The DDCAT evaluates 33 program elements that are subdivided into seven dimensions: Program Structure; Program Milieu; Clinical Process (Assessment and Treatment); Continuity of Care; Staffing; and Training. Importantly, for organisations participating in a formal quality improvement/accreditation process, the DDCAT self-assessment process provided useful evaluation evidence to support those systems. Organisations were able to undertake the self-assessment at an appropriate time to integrate with their overall quality improvement plan. Organisations were required to report to DOHA when they undertook the self-assessment and their overall score obtained through this process as well as their average score for each domain.

The DDCAT template also informed the Cultural Change Questionnaire developed for this research project.

Overview of the Research Project

ConNetica on behalf of QNADA conducted this research project as part of the *Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative* (ISI) in Queensland. The research project became known as the Cultural Change Research Project. The project commenced March 2011 and concluded in early June 2011.

Project Aims

The aims of this research project were twofold. The first aim was to document the processes of cultural change that had evolved during the program. The second aim was to use the findings and lessons learned to develop cultural change tools and resources to assist the drug and alcohol sector in Queensland as it undertakes further cultural change in the future.

Project Methodology

The Cultural Change Research Project methodology comprised three phases:

- Pre-research and development of the research tool;
- Interviewing and data analysis;
- Preparation of the research report.

Each of these phases is discussed in turn.

Phase One: Pre-Research and Development of the Cultural Change Research Questionnaire

The ConNetica Research Team familiarised themselves with the guiding documentation of the Baseline Study and other relevant project information. The key elements of the Baseline Study were analysed and a summary prepared for each agency in relation to their respective data and information.

A research questionnaire was then developed and piloted and workshopped with two of the participating agencies. The purpose of the questionnaire was to assist agencies to reflect on:

- How changes to improve services to clients with both mental illness and drug and alcohol problems came about;
- What worked, and what didn't and why;
- What strategies, processes, resources or tools proved helpful;
- What has been learned within the agency about organisational cultural change and building capacity to achieve and sustain cultural change;
- What agencies have learned about undertaking and participating in a national and sector-wide project aimed at organisational cultural change; and
- What strategies they would recommend if further cultural change projects of this nature were initiated in the future.

During this initial period, ConNetica liaised with the Project Coordinators of each of the 11 participating agencies to:

- Review and check the Baseline Survey data summary;
- Receive and discuss agency feedback about the draft questionnaire;
- Organise interview times with Project Officers and other representatives of their organisations wishing to be interviewed; and
- Discuss the possibility of obtaining examples of initiatives that demonstrate useful and helpful cultural change strategies, tools or processes.

Following the brief piloting, the cultural change questionnaire was finalised (Appendix 3). In view of the tight time frames of the project, the questionnaire was forwarded to each person to be interviewed so that they could prepare for their interview.

Project Officers were invited to provide examples of processes or initiatives that reflect or capture change occurring during the project.

Phase Two: Interviewing and data analysis

Interviews with the Project Officers of each of the 11 agencies were conducted face-to-face as per scheduled dates and times. Each Project Officer was provided with the opportunity to validate discussion of the information they provided.

Data and information from the interviews was progressively recorded and analysed using an Excel-based database. The data and findings were compared with Baseline Study trends and data analysis. Themes, cultural change processes and their impacts, and lessons learned were progressively identified.

Phase Three: Preparation and presentation of the project report

Following the data analysis, this report, identifying the methodologies used by each organisation to change organisational culture and to build the capacity of their services to meet the needs of dual diagnosis clients, was prepared.

Part Two: The beginning of the journey

Part two of the report outlines some of the ways in which the ISI agencies came to understand 'cultural change' and its role in enabling improved service for people with comorbidity.

The Baseline Study required agencies to assess and describe the capacity of their respective organisational cultures to accommodate people with comorbidity in their communities.

The Baseline Study's documentation provided a series of prompts for agencies to consider as they began to identify and understand their organisation's culture(s) and whether and how it needed to change in order to improve services for people with comorbidity.

Understanding cultural change, the processes for commencing change, articulating what needed to change and the early challenges and difficulties are examined here.

Coming to grips with 'cultural change'

From the outset, the funded organisations in Queensland (ISI agencies) understood that this was not going to be an easy project. The importance of organisational cultural change to improving services for people with alcohol and drug and mental health comorbidity was realised at an early stage.

This section outlines some of the ways in which the ISI agencies came to understand 'cultural change' and its role in enabling improved service for people with comorbidity.

Initial reactions

The Baseline Study required agencies to assess and describe the capacity of their respective organisational cultures to accommodate people with comorbidity in their communities.

The Baseline Study's documentation provided a series of prompts for agencies including:

- Are personnel, including management committee members, clinical and non-clinical staff and volunteers, likely to be resistant to comorbid clients or changes in practice to accommodate them and, if so, what can be done to improve this?
- Are current clients likely to be resistant to comorbid clients and if so what can be done to improve this?
- Do Rights and Responsibilities policies and procedures need to be adapted?
- Do risk management strategies and practices need to be improved? Are activities and environments safe for consumers, carers, families, staff and the community?
- How are clients and family members included in the organisation? Could this be improved? Do they have representation on the management committee/board?
- How are minority ethnic and cultural groups included in the organisation? Do they have representation on the management committee/board?
- Should accreditation under Mental Health Service standards be undertaken?
- What processes need to change so that there is conformance with the National Comorbidity Clinical Guidelines?
- What documents need to be reviewed to ensure comorbidity practices are integrated into operations across the whole organisation?
- How can change in organisational culture be monitored over the project?

As agencies considered these questions, they also began the task of identifying and understanding their organisation's culture(s) and whether and how it needed to change in order to improves services for people with comorbidity.

Initial Reactions: a collection of staff views.

You want us to start working with whom???!!!

We are an AOD agency not a mental health agency.

We don't work with people on psychiatric medication.

Some indication of how working with people with mental illness sat within the culture of agencies emerged as managers and Project Coordinators began to discuss the project with staff. The views of staff

toward clients with mental health conditions reflected many of the same views within the general community.

For some agencies, it wasn't so much that they routinely turned away people with mental illness but that they either didn't identify the mental illness or held the perception that they could not respond effectively to anything beyond 'mild' or 'uncomplicated' mental illness.

The question for the ISI Project Coordinators and managers then became 'if resistance to working with people with mental illness or with complex needs arising from mental disorders is part of our culture, how can a different prevailing culture be created and what are the starting points?'

There is too much risk... people with mental illness will make the place unsafe.

You are trying to 'psychologise' this place when we are an alcohol and drug agency.

And so the starting point for most of the ISI agencies became the realisation and recognition that there was significant resistance to working with people with co-occurring mental illness.

We don't 'do' mental illness at all well and as an agency we have tended to turn away people with co-existing mental illness.

Defining cultural change

Barney (1986) described culture in organisations as the psychology, attitudes, experiences, beliefs and values (personal and societal values) of an organisation.[10]

Organisational culture has been further defined as:

"... the specific collection of values and norms that are shared by people and groups in an organization and that control the way they interact with each other and with stakeholders *outside the organization."*[11]

Culture is about shared ways of thinking, how people behave and interact, what they think is important – 'the way things are done around here'. In many ways culture is the unwritten and unspoken aspect of an organisation, shared by its members. Culture can have a strong influence on day-to-day organisational behaviour and performance.

Culture can work to the benefit or detriment of organisational success. A well-defined culture helps organisations respond to external pressures, as it enables members to clearly understand the organisation's mission, strategies and goals in relation to the external environment. Culture also supports internal integration, as members work together effectively on organisational activities. Organisations may derive benefits from developing strong and productive cultures including:

- Better aligning the organisation towards achieving its vision, mission, and goals;
- Higher staff motivation and loyalty;
- Increased cohesiveness among the various business units or teams;
- Promoting consistency and encouraging coordination and control;

[10] Barney, J. B. 1986, 'Organizational Culture: Can It Be a Source of Sustained Competitive Advantage?', Academy of Management Review, Vol. 11, no. 3, pp. 656-665.

11 Ravasi, D. and Schultz, M. 2006, 'Responding to organizational identity threats: Exploring the role of organizational culture', Academy of Management Journal, Vol. 49, no. 3, pp. 433–458

- Shaping employee behaviour at work, enabling the organisation to be more efficient.

According to Schein[12], culture is the most difficult organisational attribute to change, outlasting organizational products, services, founders and leadership and all other physical attributes of the organisation. Schein and also Kotter [13] claim that most organisational change efforts fail because of a lack of appreciation for the role of culture and the need to address cultural change above other elements of the change process.

During this research project organisational culture came to be understood as the sets of shared values, assumptions and attitudes that guide interpretation and action in organisations by defining appropriate responses and behaviour for various situations and with different groups of people. It became clear that organisational culture whilst not static is grounded in the collective histories of an organisation and embedded in organisational metaphors, symbols, myths, and stories, and in the behaviours of those who relate to it including staff, Board members, clients, funders and the community.

It also became clear that the agencies discovered for themselves what cultural change meant or comprised as the project progressed. From the descriptions and accounts of agencies, cultural change involved uncovering an organisation's core sets of values and beliefs, identifying incongruences between the current culture and that to which the organisation wishes to commit and establishing new norms and values and then embedding the new culture by allowing the new milieu to change what the organisation does and how it operates. It is then important for these steps to be repeated over a longer period of time. Cultural change can be reinforced by ensuring that as new members enter the organisation, they are surrounded with clear messages about the culture they are entering as well as ensuring there are opportunities for acknowledgement, celebration and reward of desirable organisational change and achievement.

Processes for coming to grips with 'cultural change'

Different processes for identifying what aspects of their culture needed to change and how change might be achieved were undertaken by the agencies. Some had initially thought or hoped that if they just proceeded with developing and implementing a project plan based on the results of the Baseline Study the cultural issues would dissipate. Others had thought that the cultural change required would become clearer as their agencies progressed with the quality improvement accreditation processes. Despite the difficulty of the task most agencies formed the view that they needed to be clear about what needed to change from as early as possible. This view was reinforced by the Baseline Study's requirement for agencies to assess their culture and to identify what would help or hinder improved services.

Some of the key processes for 'coming to grips' with the required cultural change included extensive research and discussions internally with other ISI agencies and with other organisations.

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[12] Schein, E. 1990, Organisational Culture American Psychologist, vol 45, no.2 p 109-19

Accessed via http://www.blueconsultoria.com.br/wp-content/uploads/2009/07/Organisational-culture_E.-Schein.pdf

[13] Kotter J and Cohen, D. 2002, *The Heart of Change*. Harvard Business School Press, Boston Mass.

Strategic internal discussions

It was clear that a number of the agencies had a degree of hesitancy and tentativeness about embarking on the change process. Funding for capacity building and cultural change were novel. Developing a shared understanding and some common language around the changes was a first step.

'Capacity building' and 'cultural change' were difficult terms. Our agency had discussions internally, some planned but many unplanned and over coffee, about what all this meant to us – how we could interpret it so that it made sense to our staff and clients, was relevant to our services and programs and could work for us and where we were wanting or needing to go as an organisation.

One agency for example decided that they needed to change whatever was necessary to foster a culture supportive of their aspiration to become '*specialists in comorbidity'* meaning by this becoming an agency with highly developed expertise in working with people with both alcohol and drug problems and mental illness.

Once agencies determined or had a growing sense of what they wanted their culture to change to, the next questions were: -

At an organisation level we started to reflect on what in our culture needed to change. Another way of viewing this was what did we want our culture to change to? What did it need to change to if we are to provide services to people with comorbidity? This made the concept more concrete and relevant.

- What do we need to do to become specialists in comorbidity?
- How do we resource and support staff?
- How do we translate that improved skills and knowledge into improved comorbidity services? i.e. not just improved skills and knowledge in mental health but combining that with AOD skills.
- What attitudinal changes are required and how do we do it?

Discussions and brainstorming processes of this nature appeared to have occurred within each of the ISI agencies.

Discussions between ISI agencies and with other service

The ISI Project Coordinators also discussed and agonised over the question and meaning of cultural changes with each other. Some had used the questions in the Baseline Study about cultural change to help them get started, others were still trying to pin point just what needed to change.

One agency, whose project planning and implementation had been a stop/start process because of difficulty with recruiting and retaining a Project Coordinator, simply decided that they wanted to change to be inclusive of people with mental illness and wanted to offer specialised therapeutic services for their client groups but did not know where to start. They opted for a 'humble approach' of drawing on the ideas and expertise of local stakeholder organisations and services.

In this instance, the Reference Group became a vehicle that helped this agency to determine what it wanted to change and to glimpse the agency it wanted to become.

Instead of stumbling around we decided to approach it with humility by drawing on help from outside agencies who we invited to be members of a Reference Group. We invited a very diverse group and to our surprise most turned up. QLD Health was very supportive and willing to work with us. We had common needs. We could reach groups they couldn't and they had expertise we didn't have that would make a difference to these groups of clients. The Reference Group led surprisingly quickly to improved referral pathways, better referral forms and joint case management opportunities. The Reference Group also informed our redesigning of our intake process. The Reference Group although it morphed into something else was critical to change getting underway.

The crux of cultural change: articulating what needed to change

The process of articulating what in an organisation's culture needed to change if that agency were to provide improved services to people with comorbidity varied – for some there was a moment of inspiration when the required change was crystallised in the minds of key players. For others, it was a more gradual process. For most, one change led agencies to aspire to further changes.

Articulating what needed to change

Some of the understandings that emerged about what needed to change in an agency's culture include the following.

Not being good at providing services to people with mental illness

Most of the ISI agencies identified that they needed to change whatever it was in their culture that was hindering them from working with people with mental illness in the first instance. For some who were already working with people who had a mental illness, it was more about how they could work more effectively with this group or how they could work with increasingly complex levels of need.

Many staff were reluctant and fearful of people with mental illness. Some key staff were particularly against working with people with mental illness.

Mental illness had been an area we had not done well with in the past despite many of young people having comorbidity.

A number of agencies openly expressed a fear of working with people with mental illnesses. This was even the case when there was recognition that many younger clients had co-existing mental illnesses and yet the identification of clients with mental illness had not developed within services.

Traditionally, a number of the agencies recognised that the issue with depression and anxiety was not so much whether people with these conditions were accepted into service but whether the conditions were identified.

Our organisation had limited understanding of mental illness …. . If a client also had mental illness we would frequently move them on, particularly if their illness was severe or if they needed medication. But increasingly there was nowhere to move them on to. We were of the view that they were someone else's clients and responsibility.

The view that people with mental illness were not our responsibility

As reported in other studies, Project coordinators found that staff in the AOD agencies saw clients with mental illness(es) as someone else's responsibility. This appeared to have been a commonly held view among a proportion of staff in most of the agencies. Clients with more severe levels of illness or requiring medication were unlikely to be provided services and 'moved on'. Some agencies said it was becoming increasingly difficult to move them on to another service – this may have been due to the increasing demand for mental health services generally.

Somewhat paradoxically, services also recognised that if they continued to focus on clients with only a substance use disorder, then the service would be treating few if any clients.

The risk of being an irrelevancy to the client base

Though levels of comorbidity had increased among the traditional client base of AOD agencies, some agencies or some of their programs had not changed accordingly or had resisted change and were at risk of being irrelevant. Some agencies even acknowledged they were aware of the declining relevance to their clients but the prevailing culture was resistant to change.

> *AOD agencies like ours had been struggling to retain relevance to people using drugs because of the high level of comorbidity. Our traditional client groups had changed but we and other agencies had been refusing to see it or acknowledge it… These changes had been demanding that AOD agencies like our own accept people with mental illness… But we had been out of step with the real world and the lives of our client groups.*

Not open to change and just wanting to do what we had always done

All of the ISI funded agencies identified a tendency within their organisation of not wanting to depart from long established polices, practices and programs. In stressed systems, resistance to change can be greater and that appears to have been a factor with the agencies.

> *The hardest thing to change were the set views about what was or wasn't a therapeutic community or a residential program, what a therapeutic community or a residential program could or could not do, or who could be worked with and who couldn't be.*

Afraid of making the transition to a new generation of alcohol and drug treatment services

Some agencies were aware that they had made significant changes in what their services did and how they operated. They were however aware of the potential to forge yet further new service models if they continued to widen the reach and composition of their partnerships. But first there was the issue of mitigating risk internally or at least the perception of risk.

Working in a silo

Alcohol and drug agencies like agencies in other sectors had been inclined to work in isolation from other agencies because of a tendency to compartmentalise the needs of their clients and to see their responsibility as working first and foremost with the alcohol and drug related needs of a client. This had been changing in recent years but the problem still remains of sufficient priority being given to working in collaboration with other agencies.

> *It's hard to find the time to work with other agencies – collaboration takes time and resources that we don't have.*

A low key approach to assessment, treatment planning, client records and report writing

Assessment and treatment planning were the exception not the rule

In some of the funded agencies limited attention was being given at the start of the project to formal assessment, treatment planning and to preparing and compiling client records. Accountability, including assessment, care planning and record keeping was seen as an impost by government funding bodies which impeded client service delivery.

Minimalist approach to client outcomes

Agencies also reported that there was a limited emphasis on outcome measurement and reporting at the beginning of the project.

One of the hardest things to change was accepting that we have to do more than just sit and have a ciggy with the client.

Having identified that those were features or characteristics of what it was in their agency's culture that needed to change, the next task was articulating what the culture needed to change to.

Articulating what the organisational culture needed to change to

As with the realisation and articulation of what needed to change, understanding what the organisational culture needed to change to or become did not necessarily emerge all at once.

Becoming specialists in comorbidity

As outlined above, one agency wanted to change its culture so that it could become specialists in providing safe and effective services to people with comorbidity.

Becoming relevant again to the lives of client groups

Another agency saw the ISI project as a resourced opportunity for it to become relevant again to the lives of its client base. They saw potential clients "self-selecting out" of the service as they could see little value or utility in the services offered. The same agency described that through the ISI project an inclusive attitude toward people with mental illness developed – which they saw as a fundamental cultural shift.

Becoming specialists with complexity

One agency that was already working with people with AOD and mental health comorbidity had set its sights on becoming specialists in safely and effectively providing services to people with high levels of complex needs, the people who were frequently rejected by most agencies.

The big cultural shift for us was expanding our capacity to work with an increased level of complexity.

Becoming a leading partner in responding to the needs of people with comorbidity

Some agencies aspired to attaining cultural change so that they could become key players in a wrap-around service hub or network. They aspired to be recognised as important team player locally.

The ISI project has been very good for us; drew us into closer working relationships with a range of organisations and services whose respect we were able to regain.

Providing a no wrong door

For others agencies the cultural change they sought was that which would enable them to be a

'*no wrong door*'; an agency that effectively implements a No Wrong Door Protocol and helps every person, who makes their agency the first port of call, obtain the help they require.

Establish a multi-disciplinary team environment

Agencies realised that the complexity and acuity of client need requires a multidisciplinary approach and that there is benefit for agencies in doing so. Evidence indicates that a multidisciplinary team approach for people with comorbidity can reduce disability, morbidity and can improve quality of life. There is also evidence that decisions made by a multidisciplinary team are more likely to be in accord with evidence-based guidelines than those made by individual workers. Furthermore, client satisfaction with treatment and the mental wellbeing of staff in a multidisciplinary team has been shown to be improved by a multidisciplinary approach to care. Despite this, the ISI agencies noted that multidisciplinary practice does not just happen but rather comprises practice skills that must be nurtured and valued.

Becoming a provider of a highly regarded suite of programs

Some agencies wanted to change their culture so that it was supportive of staff increasing their level of expertise and professionalism and thereby expanding the range of quality treatments, interventions and programs offered.

Being culturally inclusive, age specific, outward looking and ever reaching out

The ISI funded agencies noted that the development of culturally inclusive practice is often something that finds its way into the 'do tomorrow bundle'. However, like multidisciplinary practice, culturally inclusive practice doesn't just happen and also needs to give priority if it is to be achieved.

> *We realised that the ISI project could provide us with the opportunity we needed to make a few cultural changes at the same time. It enabled us to become both comorbidity inclusive and culturally inclusive and to ramp up our emphasis on holistic care, physical, social and emotional wellbeing and healing and to reaching out to further groups who are also falling between service gaps ....*

Being recognised as a workplace that values and prioritises training, learning, practice and professional development and collegial relationships

Agencies observed that a key difference between a stagnant organisation and self-replenishing organisation was the emphasis given and resources allocated to professional development and nurturing of collegial relationships. Agencies came to recognise that there was a synergy between cultural changes that would help them embrace people with mental illness and the constant challenge of retaining staff. Significantly increasing the training for staff and creating a workplace more supportive of learning, reflective practice and professional development not only moved the culture forward but also created a workplace that was more attractive for staff.

Being recognised as a provider of contemporary, evidence-based and faith-based comorbidity training

Most of the ISI funded agencies had their origin in a philosophy or a commitment to a particular organisational orientation. One faith-based agency aspired to

> *The faith-based perspective was important particularly for our volunteers... We need to provide training that they could relate to and process. If they couldn't relate to it they wouldn't be able to take it on-board and allow it to change what they do – they would not have been able to embed it into their work, practice and volunteering and would not be able to take the step of working well and comfortably with people with mental illness.*

undertaking cultural change and reinvigoration so that it became recognised as a provider of contemporary, evidence-based and faith-based comorbidity training. The agency saw their development as a Registered Training Organisation (RTO) as driven by necessity given the lack of suitable comorbidity training for faith-based services.

Being recognised as a provider of a revitalised, contemporary and evidence-based model of therapeutic communities

One agency sought to address the imbalance in its service model and operational milieu that had arisen, at least in part, due to the type and nature of contractual arrangements with various funding bodies. Having been aware of this shift, and the way in which the agency had departed from some of the key tenets and philosophies of the therapeutic community model, the agency came to view the ISI project as an opportunity to address this imbalance and to revitalize their service model.

> *Not only was there the chance to get back to our roots but we could also redevelop our model of therapeutic communities so that it is contemporary and inclusive of people with comorbidity.*

Becoming an alcohol and drug agency that steps over the 'psychosis line in the sand'

Another agency echoed this aspiration and similarly described psychosis as having been '*the river too far'* for alcohol and drug agencies.

> *We wanted to become an agency that stepped over the psychosis line in the sand…*

Having articulated what needed to change in their respective organisation's culture and the cultural changes their organisations wanted to embrace, the Project Coordinators became clearer about what actions and strategies they could pursue.

Cultural change and the importance of the moment

The AOD sector in Queensland like other community sectors throughout Australia have found themselves surrounded by rapid and extensive change with implications for how health and community agencies are to be funded and for how they are to operate. Some of the change and developments have included the introduction of the *Better Access to Mental Health Care and Psychological Services* and the announcement of the introduction of Health Hospitals Networks, Medicare Locals, a Preventative Health Agency and e-health infrastructure. Associated with these developments are to be major changes in Commonwealth/State responsibilities and in funding arrangements and models. This will require more investment in relationship and stakeholder management, particularly as the new structures and arrangements bed down. Though just where AOD agencies fit in the scheme of things remains unclear, AOD agencies have become increasingly aware that they will be required to operate differently, namely to:

- Work in local partnerships;
- Be a player in integrated and coordinated care locally and regionally; and
- Be able to demonstrate that their services are evidenced-based and locally relevant.

Agencies have also been realising that they will be required to demonstrate strong clinical governance and compliance with relevant national standards and guidelines.

At the same time as agencies were considering the implications of these changes, new opportunities and challenges had emerged via the Australian Government's National

Amphetamine-Type Stimulant Strategy 2008-2011, Round Three of the Non-Government Treatment Grants Program and various Queensland Government funding programs. These external drivers combined with a range of internal events or trends were prompting agencies to look internally and to assess their level of readiness to successfully position themselves for growth and development or to simply remain competitive.

As the Project Coordinators of several agencies put it, there was a confluence of factors that presented exciting but tough opportunities for agencies. It was tough because of the apparent size of the task and the breadth of the change required. And that's where the timing of the *Improved Services Initiatives for People with Drug and Alcohol Problems and Mental Illness* was significant.

In effect the ISI Capacity Building Grants program provided participating agencies with a resourced opportunity to make the organisational changes necessary for the new era in the funding and operation of alcohol and other drug services. As these three agencies explain:

"The ISI tendering process arose at the same time that there was organisational commitment to change and to improving client services. Our organisation had been operating the same way for a long time, since its origin in fact and though it enjoyed a good reputation, its clientele had narrowed and with this, our approaches had narrowed and we had moved away from some of the tenets of a therapeutic community – our organisation wanted to get back to these roots."

"The timing was right. Some staff had left and had not been replaced. New contracts were on the boil and there was a sense we needed to change."

"The ISI funds coupled with other funds provided us with the opportunity to undertake QIA. This endeavour assisted us to facilitate even greaert buy-in from management and staff who could see the extent to which the ISI work dovetailed with organisational improvements required for accreditation. This created an imperative and a sense of excitement that rippled across the organisation. Undertaking accreditation and the ISI project is transforming our organisation from inside out and has enabled us to provide services to people whose needs we had known about but were not able to respond to."

Getting started: reflections on the initial process

Reflections on the Baseline Study

Though viewed as an onerous task at the time, Project Coordinators and their agencies came to view the Baseline Study as having a critical role in guiding them through the change process. As the project progressed, agencies came to view the Baseline Study as both a source of guidance and moral persuasion.

I was instructed by management to be brutally honest when compiling the base line study, to tell it like it was ….

The Baseline Study enabled agencies to document the existing culture and some of the difficulties that might arise as they embarked on increasing the capacity of the organisation to work with dual diagnosis. The Baseline Study enabled agencies to define the scope of the project after some initial ambiguity.

A conclusion leaping out of the pages of the Baseline Study was that if agencies were to effect the cultural change needed to support the improved services for people with comorbidity, then significant activity was required in all or if not, most of the action areas.

The Baseline Study process revealed that at least 60% of our clients have AOD and mental health comorbidity as well as a range of other conditions and care needs. All of our staff had contributed to the Baseline Study that helped to gain support for the project throughout the organisation – the Baseline Study clearly indicated the need for us to participate and the project funds gave us the capacity to.

Early challenges and difficulties

Agencies faced many early challenges ranging from recruitment, organisational resistance to change and being able to source expertise, training and support at a sufficiently early point.

Difficulty with recruiting and/or retaining a Project Coordinator

Most of the agencies struggled to recruit a Project Coordinator with an appropriate experience and skill set. Some had relevant clinical experience in mental health but not in alcohol and drug programs and vice a versa, others had relevant project management experience, others had experience in managing people, whilst others had organisational change management experience – but it was hard to find someone with all of these skill sets. As a result, the retention of a Project Coordinator was uncommon in the first twelve months of the project. On losing a Project Coordinator some agencies took the opportunity to consider how they could restructure the position with some choosing to redistribute responsibility for the project's coordination to a number of program managers.

Sense of being overwhelmed by the Baseline Study's findings and internal reactions

Irrespective of skill set and experience there were many a moment when most of the Project Coordinators felt overwhelmed by the enormity of their task and the immediate responsibilities of trying to work out where to start, what priority to give to different actions, what to do first and how to get sufficient initial level organisational support for the change process.

An early and time-consuming challenge was the preparation of the project plan.

In effect, there was a month to plan each of the three years' of the project – three months in total!

After completing this plan and after having obtained management approval, most of the Project Coordinators had misgivings and doubts about the plan – its poignancy, relevance and achievability.

Reactions to the Baseline Study and to the project's beginnings

Most Project Coordinators also had moments of feeling overwhelmed by reactions to the project and its beginnings. Though management was generally supportive, some staff were not. Project Coordinators encountered fear and anger about the possibility of program and job changes and of staff having to do things differently.

The BLS findings did cause considerable angst though as our service model based on a traditional therapeutic community approach had resulted in an agency with limited understanding of and capacity to work with comorbidity. The support of the Executive Director of the goal of increasing our capacity to work with comorbidity led initially to further fear and concern among staff.

Some common starting points

Once the Project Plan had been completed there were a number of common starting points including:

- The Board and CEO affirming the Baseline Study, the Project Plan and the need for change;
- Obtaining wider ownership internally of the need for change;
- Establishing an early focus on the relational and supporting staff to be a part of the change; and
- Establishing strategic external partnerships.

Considerable time and energy was devoted to managing concerns and fears among staff about the change. One Project Coordinator described this task as one of the hardest aspects of the role.

Many of the Project Coordinators had moments where they felt ill- equipped to handle all of these tasks at the one time. Some left, whilst others stayed.

> *I doubt that the level of personal wear and tear when there is no or little organisational distance from where change needs to occur was widely understood… we were and still are located in the same open plan office space. We are right there where the change needs to occur.*

Making some early progress

Most Project Coordinators commenced with a review or audit of their organisation's policies and procedures and with a review of the research and literature to determine what treatments, programs and services were evidence-based and/or best practice for people with alcohol and drug problems and mental illness. Incorporation of co-morbidity in agency mission statements and subordinate policies and procedures was pivotal for many agencies.

> *We started with the Baseline Study and mapped out what we needed to do. We then started work on our organisation's policies and procedures and mission statement so that comorbidity and mental illness were included and integral to everything this organisation does.*

Some used the research to develop and apply a comorbidity best practice checklist and a comorbidity skills audit so that they could have clearer and more detailed benchmarks.

Whilst doing this largely desk-based initial work, Project Coordinators also commenced setting in place processes for staff to be involved in and informed about the project –

- Weekly newsletters (e.g. Weakly Gleanings);
- Weekly or regular staff meetings (e.g. College of Counsellors);
- Internal working or reference groups to guide the project and change processes (e.g. Restructuring and Evaluation Working Group, training Review Committee, Assessment and Case Management Review Committee, Case Conferencing Working Group etc.);
- Introducing the Plan Do Act Complete (PDAC) cycle as a means of giving staff voice;
- Circulation of research synopses and interesting articles or information pieces; and
- Formal and informal consultation meetings.

Most agencies also established processes for obtaining the advice and input of external experts including clinical review or reference groups. Such mechanisms assisted in opening the agency to external expert influence and helped to create ownership and deeper understand among staff who developed draft protocols for the reference group's review.

Most Project Coordinators also gave early priority to sourcing as much training as was possible. This included people who spoke about their own experience of living with mental illness and/or comorbidity. Other training provided at this stage included:

- Introduction to mental illness (e.g. Nuts and Bolts of Psychiatry);
- Mental Health First Aid;
- Suicide awareness and prevention training (e.g. ASSIST);
- Psychiatric medications and their management;
- Handling difficult situations;
- Non-violent Crisis prevention Intervention training; and
- The No Wrong Door Protocol.

Agencies noted that staff response to this training was positive and helpful to the project's progress. Further interest in the project was created as Project Coordinators began to broach with staff their interest in the project providing opportunities for the undertaking of training leading to a formal qualification. The provision of initial training and the prospect of attaining formal qualifications began to act as a counteracting force to concern and resistance to change.

The dovetailing of the quality improvement accreditation processes with the ISI capacity building project also assisted in promoting greater organisational ownership.

A common frustration

Though all the Project Coordinators were undertaking similar sets of tasks, at this early and crucial stage of the project there were no mechanisms in place for collaborative planning, resource development and collaborative sourcing of training and other external services and for the sharing and pooling of resource and expertise.

Part Three: Cultural Change

Part three of this report provides a discussion on the pathways taken by the agencies to achieve cultural change – these are the explicit and implicit cultural change processes, events and models used. Some of these were drawn from the literature, others were developed from the discussions within the agencies.

From the research a number of observed change pathways are defined and the key activities, strategies and events for each pathway is provided. A synopsis of the key outcomes and strategies in the 10 key action areas for the project is also provided.

From the evidence collected, the tools and resources developed or used by the agencies are then listed under a series of Cultural Change Resource Inventories.

Cultural change pathways

The Project Coordinators conducted extensive research to identify relevant and effective strategies and pathways for cultural change. It would appear that agencies drew on a number of different research and theory informed approaches as well as on internal experience and intuition. '*Cultural change pathway*' came to be understood during the research project as key defining points at which change started to occur or was first evident and the processes and sequences of events leading up to and surrounding those points.

No single approach or pathway dominated but rather it appears that the pathways differed according to traditions within each organisation, project phases, the goals being pursued and the different tasks being undertaken. It was more like a 'patchwork' approach or a 'snakes and ladders' approach where the journey of cultural change headed down one track only to diverge out along different, crisscrossing paths as different outcomes were pursued.

It was possible to glimpse approaches that were reflective of cultural change methodologies and frameworks outlined in the research and literature. The capacity building approaches of Crisp et al (2000) posited four inter-connected domains for capacity building and change:

- A top-down organisational approach which might begin with changing agency policies or practices;
- A bottom-up organisational approach e.g. provision of skills to staff (or engaging clients and carers in planning);
- A partnership approach which involves strengthening the relationships between organizations;
- A community organising approach in which individual community members are drawn into forming new organisations or joining existing ones to improve the health of community members.[14]

The Baseline Study document provided by DOHA notes that some commentators argue that change will be neither significant nor sustained unless more than one, or all, of the approaches are used.

One ISI agency found Bolman and Deal's Four Frame Analysis[15] approach to leadership and analyzing change in organisations useful: -

The Structural Frame - The "structural" approach to leadership and change tries to design, plan and implement a process or structure that will be appropriate to the new requirements, the problem or the circumstances. Steps include:

- Clarifying organisational goals;
- Managing the external environment;

[14] Crisp, B, Sverissen, H and Duckett, S 2000, 'Four approaches to capacity building in health: consequences for measurement and accountability', *Health Promotion International*, Vol. 15, No. 2

[15] Bolman, L.G. & Deal, T 2008, *Reframing Organisations: Artistry, Choice and Leadership*, Jossey-Bass, San Francisco

- Developing a clear structure appropriate to task and environment;
- Clarifying lines of authority;
- Focusing on task, facts, and logic, rather than on personality and emotions.

The Human Resource Frame - The human resource approach focuses on people as the 'heart' of any organisation and attempts to be responsive to their needs and goals to gain commitment and loyalty. The emphasis is on support and empowerment. This approach seeks to empower people through participation and attempts to gain the resources people need to be a part of the change. The leaders of this change confront when appropriate but try to do so in a supportive climate.

The Political Frame - In this frame the leaders of change focus on the political reality internal and external to an organisation and understand the importance of interest groups and being aware of their different interests and agendas. This leader understands conflict and limited resources. The leader of this approach identifies and recognizes major groups and seeks to develop ties to their opinion leaders. Conflict is managed as power bases are built. Arenas for negotiating differences and coming up with reasonable compromises are created. The leaders of change also work at articulating what different groups have in common and help to identify external threats or barriers to the change they desire.

The Symbolic Framework – In this frame the leaders of change focus on vision and inspiration and seek to organise people around this vision. Symbolism is important as is ceremony and celebration to communicate a sense of organisational mission, unity and achievement. The leaders operating within this frame tend to be very visible and energetic and manage by walking around. These leaders often rely heavily on organisational traditions and values as a base for building cohesion and shared meaning around a common vision and a desired culture. [16]

Viewing the change processes that unfolded within the ISI agencies through the lenses of this Four Frame Analysis, it is possible to see aspects of each frame to differing extents, in relation to different objectives and at different stages of the change processes. Also evident are various steps in Kotter's staged approach to change.[17] Kotter's model of organisational cultural change comprises eight steps:

1. Creating a sense of urgency – helping others to see the need for change and the importance of acting immediately;
2. Pulling together a Guiding Team – one with leadership skills, credibility, authority and analytical skills;
3. Developing the change vision and strategies;
4. Communicating for understanding and buy-in;
5. Empowering others to act;
6. Working together for short-term wins;

[16] Bolman and Deal's Four Frame Analysis: Case Study, Viewed on 29 March 2011 < http://essayinfo.com/sample/essay/775/2/>

[17] Kotter, J 2006, *Our iceberg is melting: changing and succeeding under any conditions*, MacMIllan, London

7. Not letting up;
8. Creating a new culture and making it stick – 'holding on to the new ways of behaving, and making sure they succeed, until they become strong enough to replace old traditions'. (2006, pp. 130-131)

Kotter's model views organisational culture as the shared values, norms and expectations that guide organisation members in terms of how they approach their work and how they deal with each other and with other people. Organisational cultural change involves the formulation and establishment of new sets of values, norms and expectations that in turn lead to changes in how an organisation operates and in the practice of employees.

Kotter emphasises the need for a change leadership alliance or Guiding Team in order to shift the prevailing organisational culture paradigms and to foster openness to change.

Some observed change pathways

Upon reflecting on the Project Coordinator's accounts of the ups and downs and twists and turns of change in their organisations, and drawing on the theoretical approaches discussed above, the following schema of pathways is proposed:

- Watershed Pathway;
- Empirical and Structural Pathway;
- A Hearts and Minds Practice-Centred Pathway;
- A Community-based and Partnership Centred Pathway; and
- A Cultural Change 'Creep' Pathway.

Though presented as different pathways, in reality it is apparent that aspects of each pathway were operating in each agency at different points throughout the project.

A Watershed Pathway

This pathway was characterised by activities in each of the four domains outlined by Crisp et al and had similar emphases to those of the *symbolic and human resource frames* of Bolman and Deal. In some agencies it also involved action through the lens of the *political frame*. The articulation of a new vision and a new direction for the agency was fundamental to this pathway. Change progressed as the Board, management, staff, clients and the community pulled together around a shared sense of an imperative for change. It was a decisive point of time when the organisation would strive for a significant leap forward.

Attention to Kotter's steps of 'creating a sense of urgency', developing the change vision and strategies, communicating the vision to promote buy in and empowering others to act was apparent.

For some it was the logical next step in the organisation's development, for others it was a point of reinvigoration or of providing significantly improved services. For some it involved becoming specialists in comorbidity and/or complexity whilst for others it involved providing an expanded suite of high quality, evidenced-based treatments and programs suited to the organisation's client groups.

In most agencies it involved synergy between the organisation's aspirations and new directions and the change necessitated by quality improvement accreditation processes.

Table 1 Watershed Pathway Key activities, strategies, events and points along the way
Articulation of a turning point for the organisation or of a new vision
Board backs new directions and the imperative for cultural change
Broadcasting of the new directions and change – staff, clients, community, partners, key stakeholders
Client participation strategies – learning from the voice and lived experience of clients
Revision of corporate documentation and policies and procedures to incorporate change
Culture change entwined with quality improvement/accreditation process
Change in organisational structure to support change
Strategic workforce development, extensive training opportunities and staff up-skilling
Clinical leadership, clinical governance and staff supervision
Setting in place necessary infrastructure e.g. assessment tools, case management and care coordination processes/tools, client information systems, facilities
Strategic expansion of partnerships
Program and service development

By the time the organisations had bedded down the cultural changes, the new directions and the new services, discussion was already occurring of possible further development and evolution.

An empirical and structural pathway

This pathway was characterised by activities in the *top down* and *partnerships* domains outlined by Crisp et al and had similar emphases to those of the *structura*l and *political frames* of Bolman and Deal. Forming the basis for change was empirical and factual, with information derived from audits of the organisational performance against comorbidity practice and service evidence base and best practice, quality improvement accreditation requirements and relevant national standards and guidelines.

Attention to Kotter's steps of creating a sense of urgency, pulling together a Guiding Team, producing short-term wins and sustained effort (or not letting up) were apparent.

Table 2: Empirical and Structural Pathway Key activities, strategies, events and points along the way
Analysis of the implications of Baseline Study with management and confirmation of the need for change
Assembling of an evidence-base, best practice guide and relevant standards and guidelines
Presentations by people with lived experience
Benchmarking of P&Ps and then audit compared against the evidence base and standards and identification of organisational strengths and weakness
Presentation of the state of play to management and staff: this is where we are at now? This is where we need to be; how do we get there – what do we need to do; this is a plan to guide how we get there
Conversations with management about how to proceed
Confirmed imperative for change
Management formally and publicly endorsed findings and need for change
Decision to rely on evidence-based, validated or best practice instruments, tools and resources endorsed by management
Leveraging from external and co-occurring events – e.g. signing of new contracts with funding bodies that required more staff with clinical and professional qualification, expertise and registration or accreditation with a professional – current staff without formal qualifications offered training and professional development options
Identification of champions and those who were opposed – empowering and harnessing the former and discussions with the latter about their options
Training and up-skilling– ongoing throughout project, audited and evaluated
Partnership audit initially and then focus on building strategically necessary and helpful partnerships throughout project
Rewriting of P&Ps based on review of the evidence and best practice – comorbidity woven in

Program restructure in line with evidence and best practice featured heavily along the Empirical and Structural Pathway. Further key activities, strategies, events and points included:

- Restructuring of programs and positions based on the review of the evidence and best practice – employed team leaders/managers with relevant experience and more program staff with relevant experience;
- Redesigned programs so that there are evidence based and inclusive of comorbidity – clearer or new models of service and stronger program/clinical governance - (Program manuals, Staff Workbooks, Client Workbooks and reflective journals);
- Development of new evidence-based or best practice-based programs;
- Introduction of a new client assessment and service delivery information system and outcome and performance measures.

At key points along this pathway, quality improvement cycles were prominent with progress being audited, charted and discussed internally. Project plans and timelines were readjusted where indicated and if necessary and possible.

Attention was given to planning for sustained change and to assessing the sustainability of change, particularly with a view to identifying what is not currently sustainable.

A hearts and minds practice centred pathway

This approach emphasised practice development and collegial relationships. This pathway was characterised by activities in the *bottom up domain* outlined by Crisp et al and had similar emphases to that of the *human resource frame* of Bolman and Deal.

It was an approach that gave priority to creating opportunities for staff to air and vent their anxiety, fear and anger about working with people with comorbidity as well as working in a more multidisciplinary team environment. An environment was created where staff had permission and support to talk about the tensions inherent in working with people with comorbidity alongside more traditional AOD agency client groups.

Enabling staff to identify and discuss these tensions helped them to integrate their practice approaches rather than treat both groups as discrete and separate. Discussing the tensions inherent in working within a multidisciplinary team was also key to supporting staff.

Along this pathway cultural change and the significant improvement of practice and services were fostered through strategies to engage and win both the 'hearts and minds' of staff.

Table 3: Changing Hearts and Minds Practice Centred Pathway
Key activities, strategies, events and points along the way

Findings of the Baseline Study and the need for change endorsed by management
Lead and teach by doing and sharing approach favoured - establish 'street cred'
Collegial group processes for discussing impact of desired change on practice and positions – allow and encourage venting – 'normalise reactions to change'
Change embedding and saturating through collegial processes and quality improvement accreditation processes and cycles
Link cultural, program and practice change to familiar theoretical frameworks
Introduction of processes, resources and supports for practice and professional development, supervision and opportunities to contribute expertise and to pursue further development in areas of professional interest/passion
Extensive collective training opportunities as well as training opportunities to support the specific interests of individuals
Establish processes to widen horizons by linking staff to external experts
Establish processes to encourage staff creativity and input and to have their ideas refined and validated by both management and external experts
Introduce new P&Ps, new assessment, treatment planning, care conferencing and client information systems in a way which doubles as education and professional development for staff

As with Kotter's model, this pathway emphasises that a shift in the prevailing organisational culture or paradigm will not occur without a corresponding shift in personal paradigms or in the hearts and minds of key players including the CEO. An important point along this pathway included obtaining a critical mass of staff that came on board as champions of the cultural change and of the improved services initiative. Their support for the project assisted other staff to adapt and to embrace the new directions. Staff were encouraged to have input to the change and to propose new ideas for improving programs. As the ideas of staff were accepted, validated and introduced, support and momentum for change increased.

Importantly and interestingly, Project Coordinators were of the view that whilst staff that could not embrace the change left, they provided positive feedback on their exit interviews.

The reflections of a number of agencies illustrate the central themes of the Changing Hearts and Minds Practice Centred Pathway.

> *"nothing changes unless the pain of remaining the same outweighs the pain of change"*
>
> *"The Baseline Study created the imperative – we were brutally honest about where we were at – the CEO validated the BSL's findings – the organisation then had to own it."*
>
> *"enabling organisational processes to gain support and participation of staff, to enable ventilation and discussion and to enable cultural change narratives to emerge – emphasis on practice and professional development and collegial support - critical mass of cultural change champions and turnover of staff who didn't agree with the cultural ad practice changes – appropriate training and opportunity to obtain formal qualifications."*
>
> *" … new processes, systems and resources were introduced which made work easier as well as more rewarding for staff – helped to win hearts and minds benefits personally and professionally."*
>
> *"It was important to ground the change in familiar theoretical and practice frameworks/discourses e.g. using texts and resources that staff were familiar with because of the Drug and Alcohol training."*
>
> *The design and implementation of a new electronic assessment and client information system doubled as a training and education – introducing client outcomes measures whereby staff could see the results of their work and of the cultural change – reflecting on and celebrating achievements"*

A Community-based and Partnership Centred Pathway

This pathway was characterised by activities in the partnership approaches and community organising approaches outlined by Crisp et al and had similar emphases to those of the human resources and symbolic frames of Bolman and Deal. The agencies worked with other organisations and with stakeholders in the community who shared their sense of urgency and vision for more collaborative and multidisciplinary approaches to working with people with comorbidity. Kotter's step of pulling together and working with a Guiding Team with sufficient credibility, authority, influence and expertise was particularly important along this pathway. The Guiding team's involvement and collective influence and standing in the community enabled greater buy-in both internally and externally. The immediate gains and benefits of this support experienced by staff and clients in turn created greater momentum and support for change.

Table 4: Community-based and Partnership Centre Pathway Key activities, strategies, events and points along the way
Management endorsement of need for change but uncertain as to direction for change
Stakeholder advisory processes established
Appointment of a Project Coordinator to steer and manage the initiative
Stakeholder consultations led to early improvements in referral pathway and an active commitment to collaborate
Brainstorming internally and externally coupled with research about evidence-based, best practice and cutting edge comorbidity treatments and programs for organisation's target groups
Commencement of quality improvement accreditation process
Ideas firm as to the type and nature of desired change and the type of service improvements sought
Vision emerging as to where the organisation could head and what it could become
Partnerships assist with training and up-skilling of staff and work collaboratively to introduce new programs and treatments onsite
Extensive training opportunities are sourced and emerge for staff
Introduce new P&Ps, new assessment, treatment planning, care conferencing and client information systems in a way which doubles as education and professional development for staff
Local collaboration leads to further new service models
Changed office, atmosphere, intake procedures and forms to be more welcoming of complex need and more culturally safe and sensitive
Agency becomes a hub in the local community for comprehensive and holistic collaborative care and service responses

The increased capacity to work with clients with more complex needs and who are harder to reach was acknowledged by external organisations and led to increased partnerships, increased support and the possibility of yet further new service models and improvements.

Cultural change 'creep' floor pathway

This pathway was characterised by activities in the bottom up approach outlined by Crisp et al and had similar emphases to those of the human resources and symbolic frames of Bolman and Deal. It was an incremental or creeping approach which started with where staff and volunteers were at and provided training that they could relate to, process and allow to change what they did in practise. There was an emphasis on working with and alongside staff and volunteers.

Table 5: Cultural Change Creep Pathway
Key activities, strategies, events and points along the way

A realisation by management that change was needed and that this project could help and resource that change
Project Coordinator and Manager working closely together and sharing enthusiasm for the project
An early focus on involving and engaging staff
Not trying to change too much too quickly – starting with one program stream and later bringing on board other streams and at this later point responsibility for coordination of project being shared across programs
Staff participation in and contribution to the embedding and weaving of comorbidity in corporate documentation - new P&Ps drafted, workshopped and finalised with staff and then induction
Saturating the workforce with mental health and comorbidity information and training relevant to the issues they were experiencing in their jobs
Working alongside staff and problem solving together – asking staff a lot of what do you think questions e.g. 'how do you think we could address this problem?'
Focus on internal relationship and internal processes and creating opportunities for staff to vent and learn from each other
Helping staff to understand the workplace cultures and requirements of health and mental health services – reducing the cultural distance
Focus on engaging staff in quality improvement/accreditation
Focus on involving staff in networking and building external relationships
Extensive training opportunities – including undertaking of formal qualifications, free of charge, for both staff and volunteers
New database – electronic records progressively rolled out
Greater internal communication and collaboration between different programs and teams
Celebrating progress, achievements and improved services and client outcomes

These changes led to better client outcomes, more confident and more open minded workers, excitement about the improved better client outcomes, pride in being able to work effectively with people with comorbidity and complex needs, acknowledgment and progressively to recognition and respect from Mental Health Services, Emergency Departments and other services.

Conclusion

Some initial elements common to the observed pathways for cultural change were:

- Board and management endorsement of the Baseline Study and the need for cultural change,;
- Obtaining a critical mass of support internally and/or externally;
- The intertwining of the ISI with quality improvement accreditation processes;
- Staff training, up-skilling and opportunities for professional development;
- The embedding and weaving of comorbidity in corporate documentation ;
- Significant improvements in assessment, treatment planning, care coordinator processes and new client information systems;
- Significant service improvements (this had a reinforcing effect on cultural change as client outcomes were noticeably improved and as the organisation received commendation and recognition from external organisations).

Differences included the level of emphasis given to partnerships, community involvement, staff involvement and client participation, the relative balance struck between top down and bottom up approaches and the level of reliance on data and information derived from benchmarking, auditing and evaluation.

No single approach or pathway dominated but rather it appeared that the pathways differed according to traditions within each organisation, project phases, the aspects of cultural change being pursued and the different tasks being undertaken. It is possible that aspects of each of the described pathways were operating in each agency at different points throughout the project.

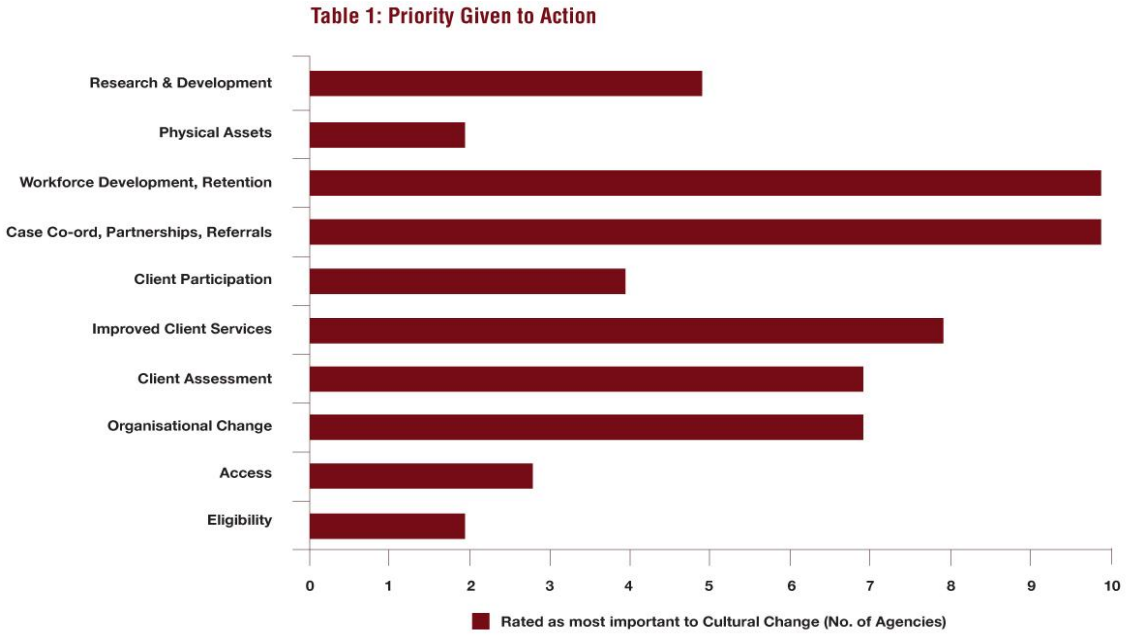
Taking the organisation with us incrementally – embedding and weaving comorbidity in all of our organisation's documentation; immersing, saturating the organisation with information about comorbidity - Staff engagement and involvement – led to new P&Ps which were owned by staff; More internal communication and strategic meetings – led to recognition of need for new client information database; Greater networking – led to more connection between ours and other services – which led to improved client outcomes; Providing staff and volunteers with the opportunity to undertake and attain formal qualifications free of charge led to engaged staff, increased commitment, upskilled staff, more confident and happy staff who were more comfortable, equipped and responsive to needs of people with comorbidity.

Key action areas – strategies and outcomes

This section provides a synopsis of some of the key strategies and outcomes in each of the Cultural Change Project's 10 Action Areas. The Resource Inventories located at the end of this section contain more detail.

Actions areas rated as most important to cultural change

The table below reveals the Acton Areas that were rated by agencies as being most important to cultural change within their organisations.



Almost all of the agencies rated '*Workforce Development, Personnel Support and Retention'* and '*Case Coordination and Partnerships'* as most important to attaining cultural change. Also rated highly were Improved '*Client Services'*, '*Client Assessment'* and '*Organisational Change'*.

Key outcomes and strategies in key action areas

Eligibility and Access

Key outcomes of activities undertaken in relation to the action areas of Eligibility and Access, included people with co-existing mental illness being more likely to be eligible for service and having more ready access to drug and alcohol treatment programs. Important strategies were:

- The rewriting of corporate policies and procedures to be inclusive of mental illness;
- Auditing access against quality improvement standards and relevant national standards and guidelines and making necessary improvements;
- Identifying and addressing barriers to access;
- Collaborating with stakeholders to improve referral pathways and care coordination;
- Widely broadcasting and communicating the change in eligibility and access throughout service networks and throughout the community;
- Cross-cultural awareness and cross-cultural practice training.

Some agencies employed Aboriginal and Torres Strait Islander staff to assist with improving cultural relevance of promotional materials and to assist in improving the cultural safety and sensitivity of intake processes.

A resource that agencies found helpful for effecting this change was the Victorian Hume District *No Wrong Door Protocol*. Agencies adopted or adapted this protocol and its training package and inducted all staff in its application. Each of the agencies trained staff in the practice skill of active referral and supervision and professional development activities emphasised the notion of collective and individual responsibility to help people contacting the agency to access the services most appropriate to their need.

Agencies updated intake processes and assessment tools to be more culturally appropriate and to promote cultural safety. Client information and client forms were also revised to be less wordy and more visual. For some agencies, comorbidity and social and emotional wellbeing were simultaneously embedded in the organisation's mission, policies and procedures.

> *"The cultural change of being inclusive of comorbidity is now entrenched – mission, policies and procedures, funding agreements, position descriptions, program descriptions, program objectives, eligibility criteria and referral forms. We have signalled to ourselves and to the community that people with comorbidity are welcome here."*
>
> *"We changed our name and constitution to reflect inclusiveness of mental health. Important as this is, we made it clear that as an organisation we had embraced comorbidity and we are here to assist people with mental illness; it formalised our mental health emphasis and led to a formalising of our mental health partnerships as well."*

Organisational change

Some of the key outcomes in relation to organisational change included the development of organisational structures more suited to the provision of comorbidity services, improved organisational processes for supporting staff to work with people with comorbidity, improved management and administration of programs and services, a higher level of professionalism, and a greater emphasis on training, clinical governance and supervision.

A further outcome was that agencies undertook a program of quality improvement accreditation and were able to progressively demonstrate organisational compliance with relevant national standards and guidelines.

As Inventory 2 reveals, numerous strategies were undertaken to achieve these outcomes including:

- Extensive internal discussions and consultation;
- Participatory processes for staff, peers and clients;
- Guiding team and engagement of champions both internal and external;
- Processes for the input from broadly-based community and stakeholder groups;
- Organisational restructure and restructuring and redesigning of positions and their descriptions;

- Extensive program and treatment evaluation;
- Comorbidity Best Practice Checklist and audit;
- Establishment of committees and working groups to guide change and development;
- Cross cultural audit.

Activities undertaken in this area contributed to cultural change by shifting organisations to being more professional, outward looking, connected to a diversity of local service networks and better structured and positioned to provide relevant services for people with both drug and alcohol problems and mental illness.

Changed and new organisational structures and processes were influential in creating a more flexible and adaptable organisational culture necessary for working with people with more complex needs arising from mental illness. Agencies had to work on the philosophical differences within their own agency as well as between their agency and others.

> *There was also a cultural shift in relation to clinical governance and supervision. Residential staff were used to running their own shows as against seeking the advice of clinical specialists and as against working in a multidisciplinary team and with so many other agencies. This has changed.*

Client assessment and client information systems

Inventory 3 details resources and tools developed by agencies to improve client assessment. Outcomes here included:

- More comprehensive assessment and intake processes streamlined with all programs;
- More defined processes for planned treatment and support;
- Improved assessment and practice skills;
- More structured and integrated approach to service delivery internally; and
- The introduction of care collaboration processes for achieving better outcomes for complex issues internally and externally.

At the level of client interface, organisations shifted to having:

- Improved and more comprehensive yet streamlined intake processes;
- Comprehensive assessment of every client;
- Better client records with improved and consistent client assessment, referral and case management forms;
- Evidence-based assessment tools and screens;
- More comprehensive understanding of each client's needs and service requirements; and
- Better communication of client information within and between agencies (whilst observing privacy principles and requirements).

The more structured and the greater the clarity of the assessment and planning processes and tools, the easier it was for staff to feel more comfortable with and confident about working with people with comorbidity. The new systems, assessment tools, case management tools and case conferencing packages served the dual purpose of achieving improved client assessment as well as being a vehicle for education, training and professional development for staff.

Once the teething problems had been overcome and staff were trained, in the new electronic and intranet-based client information systems, aspects of their work became easier. Agencies came to view the new client assessment and client information systems as being pivotal to the cultural change required to support improved responsiveness to people with comorbidity. The changes also become more accepted by clients and increased clients' willingness to seek help for their mental illness.

"The ISI Project redevelopment process went hand in hand with the accreditation process of program evaluation and improvement and with bringing in new data systems. This system and its electronic nature fundamentally transformed our assessment process and our practice."

"The ISI funding enable[d] us to address our organisation's client information system development needs. Development here went hand in hand with improved risk management and contingency planning which made staff feel safer and increased their confidence …."

"We added questions to existing intake as well as more specific assessments. Following consultation with staff we added a Mental Health General Screen to the intake form – all is OK with this now."

Improved Services

Outcomes achieved by agencies that contributed to cultural change included:

- An Increased range and quality of treatments, therapies and effective service responses to people with AOD and mental health issues and complex needs provided as a result of staff up-skilling and the establishment of partnerships and service agreements with other organisations;
- A capacity to coordinate access to primary health care to address a backlog of health care needs;
- Exchange of knowledge and skills between service providers and ISI agencies resulting in up-skilling and the breaking down of stigma within ISI agencies in relation to mental illness and working with comorbid clients;
- Increased levels of confidence of staff in their capacity to work safely and effectively with people with comorbidity;
- Increased capacity to coordinate and contribute to a more holistic response by working with other agencies who can assist clients with their housing, employment, legal, income and other needs that are important contextual factors; and
- Greater responsiveness to families and significant others of people with comorbidity.

A major service improvement achieved was the redesign of existing programs and services so that they were more strongly evidence-based and/or consistent with practice in alcohol and drug treatment and comorbidity treatment.

Routine health screens were introduced at a number of agencies through the introduction of a practice nurse/nurse practitioner. This nurse also assisted with medication management, supported clients to obtain a GP and worked with GPs to address health care needs and to initiate Complex Care Plans and/or Mental Health Plans. The nurse practitioners also assisted the ISI agencies to form working relationships with other health and mental health services and providers.

Some of the ISI agencies were able to offer holistic care by sourcing and introducing primary health care, psychological and other mental health care services, therapies and treatments. These services were provided either onsite or in close proximity. Different models and approaches were used with one agency establishing an onsite medical centre which was serviced by a mix of visiting private practitioners including GPs, psychiatrist and registrar, psychologist, mental health nurses and other health professionals. Other agencies sourced primary health care, mental health care and psychological services on a sessional and visiting basis. Others established working relationships with private providers in the local area who agreed to accept the ISI agencies' clients. The agencies then supported clients to engage with these private health and mental health professionals.

Agencies either provided access onsite to general health checks, sexual health checks, clinics for skin, eye, ear and diabetes, medication management, psychological therapies (CBT, DBT, Mindfulness etc.) or assisted clients to access these from a service partner. The services were secured through a number of means including:

- The utilisation of Medicare, PBS and Better Access-related provisions (Better Access to Mental Health Care, Complex Care Plans, Chronic Disease Management, Mental Health Nurse initiative, Nurse Practitioner Scheme etc.);
- Service agreements with professional associations (e.g. RANCZP, Australian College of Applied Psychology) and university departments enabling intern and professional training placements;
- Service agreements with Queensland Health and Division of General Practice and Queensland Health.

We have used the Better Access Scheme to offer psychology sessions on site – five appointments a fortnight all bulk-billed. It has been a hard arrangement to sustain because of the difficulty in ensuring that clients turn up for appointments. We also came to the conclusion that we needed to employ a qualified counsellor either on a full-time or part time basis. We limit who sees the salaried psychologist to clients who have a key worker and a mental health plan. The key worker assumes responsibility for making sure that clients turn up for appointments.

The extensive opportunities to undertake training enabled staff of the ISI agencies to introduce and offer a greater range evidence-based therapies and therapeutic programs including DBT, DBT Group Program, CBT, Mindfulness, Mindfulness based Relapse Prevention (MBR

prevention), Managing Anxiety, Managing Depression, Psychoeducation and skills programs (e.g. management of medication, assertiveness, anger management, conflict resolution etc.).

The employment of clinicians and their appointment as clinical directors, program managers, team leaders and practice supervisors also increased the range and quality of treatments and programs that could be offered. Their presence onsite also increased the level of complex needs that agencies could manage.

Some of the cultural changes associated with the vast array of improved client service include an organisational culture focused on:

- Providing continually improving, evidence-based treatments, interventions and programs service improvements;
- Striving to improve client outcomes;
- Lifting the level of complexity that the agency can safely and effectively manage.

Client and peer participation

A number of agencies reported being disappointed with their progress in client and peer participation. It was an action area considered by some to be fraught with tension arising from the requirement for agencies to achieve consistency with quality standards and to introduce a greater range of evidence-based specialist treatments on one hand whilst on the other hand not losing the contribution of peers and those with lived experience. Further and despite the strong tradition of peer participation and peer management in the AOD sector, the diversification of service models in recent years has resulted in a struggle for some agencies to maintain the same level of peer involvement as had previously been the case. Additionally, in AOD agencies that are not peer run or managed, a significant difference has been observed between the conventions of and expectations for participation between 'mental health consumers' and other clients.

Agencies recognised that the National Mental Health Standards are far more focused on client rights than AOD instruments. In the mental health sector there are clearer expectations around participation. This required agencies to develop a consumer voice.

Project Coordinators spoke of the importance of learning from the lived experience of clients to creating and maintaining an organisational cultural milieu that is safe and welcoming of the people for whom the services are meant. Hence, agencies were articulating a nexus between a culturally safe and sensitive milieu that learns from lived experience and improved client service and improved client outcomes. Though most agencies noted a struggle with client participation throughout the projects, significant progress was made in some, whilst a number of other agencies reported that their progress had been not as significant as they would have liked.

Strategies for peer/client participation included:

- Representation of internal committees and working groups;
- Community meetings;
- Audits of client participation in programs;

- Development and use of client satisfaction measures and instruments applied routinely throughout person's involvement with an agency including on exit and follow-up;
- External evaluations seeking peer and client input
- Consultation through forums, focus groups and one-to-one conversations;
- Consultation with families and significant others.

The Peer Leadership Program is run over two days (four hours) and is free. Comprises dual diagnosis (MH & D&A), relationships, counselling, anger management, and communication. We have produced it as a resource and would like to adapt it for volunteers and new staff. It has enabled young people to become peer workers. This program is being produced as a resource for other organisations to use

One agency developed a peer leadership program during the ISI project. This increased confidence among clients and assisted them to participate more in decision-making.

Care coordination, referral and partnerships

Agencies reported that the development of care coordination processes was pivotal to cultural change. Internal outcomes achieved in this action area included:

- Better structuring and planning of service delivery and support;
- Increased capacity to work with the more complex needs of clients with comorbidity;
- Increased confidence of staff in working with clients with comorbidity;
- Greater knowledge between different teams and programs of who is involved with a client, what is being done by whom and when, what outcomes are being sought, and what progress is being made.

Outcomes achieved by the ISI agencies as a result of the setting in place processes for care coordination with external agencies and programs included:

- Better outcomes for complex issues internally and externally;
- Improved knowledge of avenues and referral pathways for people with comorbidity;
- Improved relationships with referral partners particularly mental health;
- Improved processes for the involvement of other services and other professionals;
- Improved risk assessment;
- Improved management and communication of client information;
- Improved movement of clients in and out of mental health services;
- Improved sourcing of mental health information prior to client arrival; and
- Other services in-reaching and outreaching to the ISI agency.

Strategies employed to achieve these outcomes were numerous and are detailed in Inventory *6.* The strategies generally focussed on the development of new processes for case management and care coordination within the organisation. Once these were in place, workers extended the processes to their work with other agencies and external programs. Significant time and energy was devoted to developing resources, manuals and training to support the new processes. In

some instances the resources were developed internally whilst in others external consultants developed them.

Case management and care coordination processes and tools developed were given different names including: Case Conferencing Tool, Care Collaboration Process Package, Complex Case Management Process and Panel etc. Most were intranet-based and comprised treatment plans, treatment planning processes including client involvement, case conference and review processes and templates (e.g. meeting agenda, minutes, action plan, call out across teams and other agencies etc.). Some also comprised intranet-based self-learning packages.

The extent of emphasis given to this action area is evident in the accounts of Project Coordinators.

"We put a lot of resources into developing our care collaboration process both internally and externally. A key worker is now appointed to coordinate implementation of the action plan. Once this was bedded down internally we used it externally in our collaboration with other agencies."

"We were chuffed when Queensland Health and other agencies asked if they could adopt our referral forms and meeting forms."

Working with other agencies became the norm and no longer the exception. A focus on building partnerships went hand in hand with establishing care coordination processes. In some areas ISI agencies were key players in the establishment of locally or regionally-based comorbidity forums and networks. These forums provide platforms for discussion, resource sharing, problem solving and project implementation to better coordinate service delivery for people with comorbidity, and for developing and sustaining local inter-sectoral and multi-agency collaboration. In some instances the forums resulted in the establishment of service agreements for intern placements, job shadowing, collaborative training, onsite services and new collaborative treatment programs or services.

Agencies explained the importance of their work in the area of building partnerships. In particular the relations with Queensland Health services improved dramatically. Agencies had in-reach services including onsite health checks by a Queensland health nurse, sexual health sessions and checks, weekly clinics for physical health checks and assistance with mental health checks. There was recognition that the client's complexity of needs required partnerships with a range of providers.

Mental Health Services responded positively as they realise that we can assist them to reach Indigenous clients – a group they have not been able to readily reach and engage in the past. Mental Health Services now provide mental health checks onsite and assist us to provide therapy-based programs.

The ISI Project Coordinator position has been critical as without this resource we wouldn't have been able to focus on the relational and build such close working relationships and partnerships. Previously Mental Health Services didn't sufficiently respect our work or even know about us. They didn't come near us in the past. Now they work alongside us onsite and will drop in.

The establishment of processes for case management and care coordination, both internally and externally with partners, assisted to shift organisational culture toward greater professionalism, a no wrong door approach, greater inclusiveness of people with comorbidity and complex needs, and greater internal and self-reflection. Importantly, with these shifts, agencies also became more outward looking and more able to assume a key leadership role in local collaboration.

Workforce development, personnel support and retention

Inventory 4 and Inventory 7 reflect the significant priority given by agencies to providing training and to supporting practice development. As discussed early in the section on *Getting Started*, training initially focused on increasing confidence among staff about working with people with both drug/alcohol problems and mental illness.

> *We did a lot of work with staff, working alongside them and assisting them to better understand the complexities of working with comorbid clients particularly understanding the difference between mental illness and drug and alcohol misuse related behaviour – focused on observation and assessment skills, how to manage and support a person with comorbidity as they come down from drug use and how to tease out what was behaviour related to a person's illness, what was behaviour related to their addiction and then to understand how both sets of behaviours were inter-related and affected each other.*

Some of this strategic training occurred onsite and in situations with staff.

Project Coordinators developed a number of different instruments and applied different processes for identifying training needs including:

- Training needs analysis;
- Comorbidity Skills and practice audit; and
- Workplace Practice Questionnaire or similar instruments.

In addition to the initial training, other important categories of training included:

- Training that led to formal qualifications;
- Training enabling staff to increase the repertoire of treatments they could provide;
- Training to accompany new or redesigned treatment programs;
- Training that accompanied new client assessment, care conferencing and client information systems;
- Training to assist with change management and project management;
- Staff supervision and personnel and program amazement; and
- Training to support reflective practice and professional development.

The extensive range of training provided with ISI funding resulted in greater buy-in and ownership of the cultural changes that were being sought.

Significant resources were allocated to practice development and to supporting staff to allow them to develop their skills and to pursue training in areas of particular interest. Practice

development initiatives undertaken included practice audits, formalised process for reflective practice, resourcing of both internal and external supervision and regular meetings or forums where staff could come together and provide collegial support.

Agencies explained that as result of this greater focus on practice development staff felt more supported and more satisfied with their jobs and their work and more supported in their professional development. The project enabled agencies to address the consistent challenge of high staff turnover in NGOs.

We had to provide a safe and supportive environment and enough space for staff to face their own fears as we realised that there can be no organisational cultural transformation without individual change.

The practice initiatives helped promote a more reflective, collegial and learning culture within organisations. In this environment staff were supported in facing their own fears about mental illness and to work through the way in which their practice had hitherto been influenced by stigma associated with mental illness.

Importantly, staff were supported in developing an integrated approach to working with people with comorbidity rather than an approach that set mental illness on one side and drug and alcohol related issues on the other and attempted to deal with both separately.

"It has been interesting to track changes in work place practice throughout the project. [We] used WPQ (Workplace Practice Questionnaire for AOD) that we slightly adapted for use in relation to mental health practice. The first time we used WPQ there was not a great deal of Mental Health practice confidence; attitude wasn't too good either. Second time WPQ used: more mental health practice confidence; third time – improvement in both mental health confidence and attitude."

"We have developed a focus on and processes for reflective practice… staff meetings and external supervision. All members of staff currently have an external supervision. This has supported professional development and assisted greater staff retention as staff are more confident, felt they are learning and developing and making a constructive contribution to young lives."

Physical assets

Other than the purchase of new computer hardware and software and office fittings, only a few agencies used ISI funding to improve physical assets. When they did and as discussed earlier, it was usually in conjunction with ATS or similar infrastructure grants.

When funds were used to improve facilities the effects were significant and resulted in increased capacity to provide new services and an extended range of treatment and therapies. It also enabled agencies to provide comfortable and appropriate offices for visiting health and mental health professionals. The improvements also led to increased staff satisfaction and support for cultural change.

Research and development

Research played an important role in cultural change as it enabled agencies to gain a better understanding of the evidence base for effective services and practice with people with both

drug and alcohol problems and mental illness. As discussed earlier in the Getting Started section, Project Coordinators were frustrated by the lack of mechanisms until relatively late in the project, to enable agencies to share research findings.

Agencies also embarked on research to explore how case records could be used to facilitate learning throughout the organisation. A research project entitled *Story Lines Research Project*, explored how to quantify qualitative information from client records and case notes.

Research supported culture change by assisting agencies to increasingly redevelop their programs to be more consistent with evidence and with best practice.

Summary of action area outcomes and their contribution to cultural change

Some of the major contributions to culture change of outcomes in the key action areas are evident in the reflections of agencies.

Greater professionalism and an up-skilled workforce – a culture that values professional development and strives for improved practice

Agencies reported that the ISI initiative enhanced their organisation's capacity for training, professional development and up-skilling of staff.

Importantly, agencies reported observing a much greater commitment to and interest in practice development among staff.

Improved and expanded services – a culture not afraid of change and development

Outcomes of the ISI project that supported culture change include the following:

- Increased confidence of staff in working with young people with comorbidity;
- Interns and psychologists are now located on site and assist to break down barriers and enhance the skills and knowledge of staff;
- A visiting private psychologist whose sessions are well received and regarded;
- A significantly increased capacity to provide training on a monthly basis.

Improved and expanded partnerships – an outward looking, more flexible and collaborative culture

Confidence also increased as agencies forged more working relationships with mental health professional. Agencies reported integrated services with a visiting psychiatrist, registrar, GP, psychologists, mental health nurse through an onsite medical centre and the onsite Early Psychosis program.

Improved client outcomes – a culture inclusive of comorbidity and complexity

Agencies reported that now that they have systematic processes for routinely measuring and recording client outcomes, they are able to observe improvements in client outcomes as well as to identify areas of unmet need or areas that require more focused attention. Staff attributes improvement in client outcomes to a number of factors but commonly point to the more holistic approach to working with clients with both alcohol and drug problems and mental illness.

All of the ISI agencies reported that they are now working with people with more complex needs than was the case previously. The agencies noted that many of those with comorbidity

and/or more complex needs would have been unlikely to receive support or assistance from their programs in the past.

Capturing the tools and resources developed or used by agencies – Cultural Change Resource Inventories

The following section provides a series of resource inventories that emerged from the wealth of information provided by agencies about the processes, tools and resources they used to achieve cultural change. Each resource inventory identifies an important frame or action area critical to achieving and sustaining cultural change. The inventories are by no means complete and the ConNetica Research Team suggests that QNADA and the ISI funded agencies continue to develop and populate the inventories.

Cultural Change Resource Inventories for Improved Service for People with Drug and Alcohol Problems and Mental Illness

The Resource Inventories on the following pages provide a comprehensive and integrated set of change strategies, initiatives and resources. Importantly they provide an enduring framework for the sector to use as a repository of knowledge and resources for supporting continuing organisational change and development.

Inventory 1: Cultural Change Themes

Inventory 2: Organisational Strategies and Processes

Inventory 3: Client Assessment and Cultural Change

Inventory 4: Practice Development and Cultural Change

Inventory 5: Improved Client Services and Cultural Change

Inventory 6: Case Management and Care Coordination and Cultural Change

Inventory 7: Training and Workforce Development and Cultural Changes

Inventory 8: Partnerships and Cultural Change

Inventory 9: Cultural Change Pathways

Inventory 10: Future Strategies for Further Cultural Change

Inventory 1: Cultural Change Themes

Inventory 1: Cultural Change Themes	
What needed to change	What agencies wanted to change to – the new rebadging
A culture that was afraid of working with people who might be too hard	Being specialists in complexity
The view that people with mental illness were not our responsibility	Being relevant again to the lives of client groups
The view that we were not and could not be good at providing services to people with mental illness	Being specialists in comorbidity
Working in a silo	Being a key leader and driver in a wrap-around service hub or network
Complacency with skill base	Increasingly diverse and multidisciplinary workforce
Narrow and selective eligibility criteria, sometimes reinforced by or occurring as a result of contractual requirements; little or no assistance provided to ineligible people	Being a no wrong door – welcoming and assisting all who arrive at the services they require
Narrowly focused programs which in some instances had over time become punitive deficit-based approaches arising from requirements of criminal justice-related contracts	Strengths-based and recovery-based approaches
Being satisfied with what has always been done	Being a provider of a highly regarded and sought after comprehensive suite of evidence-based and best practice programs, treatments and therapies through a multidisciplinary team
Inward looking and not welcoming of people with complex needs	Being culturally inclusive, age specific, outward looking and ever reaching out – comorbidity inclusive and with emphasis on holistic care, social and emotional wellbeing and healing and reaching out to further groups who are also falling between service gaps e.g. young people with personality disorders and inhalant users
A level of complacency with practice skills	Being a workplace that values and prioritises training, learning, practice and professional development and collegial support

Inventory 1: Cultural Change Themes	
What needed to change	What agencies wanted to change to – the new rebadging
Training not having kept pace with social changes and the evidence	Being a provider of contemporary, evidence-based and faith-based comorbidity training
Complacency with service models	Being a provider of a revitalized, contemporary and evidence-based model of therapeutic communities
Focused on risk as against finding solutions for the mitigation of risk	Being an agency that steps over the 'psychosis line in the sand'

Inventory 2: Organisational Change Strategies and Processes

Inventory 2: Organisational Change Strategies and Processes	
Change strategy and process	**Outcomes and benefits for cultural change**
Internal consultation on Baseline Study	Provided benchmarks and directions of change Provided imperative for change
Comorbidity best practice checklist - based on comprehensive review of literature, research and discussions with experts and practitioners around Australia	Provided a framework against which to review current programs Provided directions for change
Comorbidity Audit - audit of programs against best practice check list– review of current programs: access, eligibility, assessment, case management, service provision, referral, job satisfaction, professional development opportunities, policies and procedures	Provided directions for change
Policy and Procedure Review Committee – a cross-section of managers and staff worked collaboratively to review and redevelop policies and procedures	Introduction of policies and procedures supportive of working with comorbidity Induction and orientation provided opportunity to engage staff in discussions about working with people with comorbidity; what they found difficult, were concerned about and what would help
Sign posting cultural change and organisational embedding of comorbidity - inclusion of improved services for comorbidity into vision and mission, strategic plan, policies and procedures, funding agreements, position descriptions, program descriptions and objectives; in some instances name change of organisation and/or programs	Cultural change supported by the organisational-wide mandated inclusion of comorbidity
Cross cultural audit – initially audits were conducted to assess the cultural appropriateness, safety and sensitivity of reception, organisational spaces, intake processes, forms and service user information; later audits also focussed on the structure and content of programs.	Based on the cross cultural audit updated intake process and tools so that they are culturally appropriate and to promote greater cultural safety. The next stage of this work is getting the forms more visually based and less wordy. Comorbidity, social and emotional wellbeing and healing have also be reflected in our vision, mission, policies and procedures, position descriptions etc. So in effect, the ISI Project enabled us to simultaneously embed comorbidity and culturally appropriate emphasis within our organisation
Undertaking of a Quality Improvement and Accreditation process – Healthy Communities Accreditation, QIC Health and Community Services, QIC Mental Health Services, QIC Alcohol, Tobacco and Other Drugs Services	Reinforced the imperative for the organisation to work with people with comorbidity and to increase its capacity to do so

Inventory 2: Organisational Change Strategies and Processes	
Change strategy and process	Outcomes and benefits for cultural change
'Eureka discussions' – discussions which set the scene, the imperative, the relevance, and vision of what the agency wanted to change and why; were often informal and spontaneous; once a vision and an imperative started to emerge process for promoting discussions became more planned and deliberate	Change began to be owned by staff Staff increasingly became active partners in cultural change
Work in progress participatory processes – part of weekly staff meetings designated to look at work in progress on new organisational documentation e.g. policies and procedures, position descriptions, program design, service delivery models, tools, screens etc.; research articles were also workshopped; information shared about how particular problems or issues had been remedied elsewhere.	Provided staff with regular opportunities to 'vent' and discuss their concerns as well as their ideas for how their concerns might be addressed Cultural change began to occur by process of 'osmosis' Participation in and contribution to remedies and to new programs, tools and resources increased ownership of change
College of Counsellors - a weekly staff meeting that was rebadged to draw on the expertise, experience and ideas of staff and to increase their buy-in; training activity or QI cycle activity of relevance to the project was undertaken; the ISI Project and accreditation process occurring simultaneously; employed the Plan–Do–Check–Act Cycle (PDAC) and started with common therapeutic AOD practice issues and then slowly increased emphasis and focus on comorbidity and coupled this with mental health training and the introduction of mental health resources.	Accreditation process became a key driver of cultural change; whilst cultural change supported organisation's capacity to achieve accreditation. Staff were not treated as 'empty vessels' who needed to be 'changed' – rather their expertise was drawn upon and encouraged. Working with the familiar assisted to allay fears and promoted openness to change Provided safe forum for staff to discuss their concerns and fears. Helped staff to help each other integrate their practice skills with people with mental illness with their existing skill set; helped to foster an integrated rather than separated practice
Guiding Team - CEO invited all interested staff to express their interest in being part of a team or working group that led and oversaw the project; a senior manager or Project Coordinator chaired the meetings.	The openness of the EOI process assisted to allay staff concern and emphasised management's valuing of the views and expertise of staff.
Engaging champions – at various stages of the project, staff stepped forward or were engaged as project champions. Champions were from within the organisation; from other organisations; from current or former peers and service users; and members of the community.	The internal champions promoted the project and its directions within their own teams and programs. The external champions helped to engage staff that were reluctant. The involvement of peers created enthusiasm among service users for change.
Regular internal newsletters or e-bulletins e.g. Weekly Gleanings - internal newsletters with updates and information about mental illness and comorbidity – talked the talk, used the language, engaging and humorous	Helped to engage rather than alienate. Change began to occur spontaneously.

Inventory 2: Organisational Change Strategies and Processes	
Change strategy and process	Outcomes and benefits for cultural change
Restructuring and Evaluation Working Group – this group comprised the CEO, clinical coordinators, program managers and the ISI Project Coordinator. The group looked at the changes to organisational structure and programs that were needed for the agency to improve its capacity to work with comorbidity.	Increased ownership of the project and the need for change at key managerial levels of the organisation.
Introduction of national standards and guidelines - National Comorbidity Guidelines in 2010, National Mental Health Service Standards	Provided an objective framework of standards for the organisation to aspire and work toward.
Organisational and/or program restructure – using the National Standards or best practice checklists programs were reviewed and then where necessary restructured.	The introduction of contemporary, evidence-based programs and therapies went hand-in-hand with greater professionalism, an organisational culture that valued learning and professional development and more diverse and multidisciplinary workforce
Staff Induction Packages and Processes – intranet-based and self-paced including modules on client information system, assessment tools, case management, care coordination tools, clinical governance, supervision etc.	Augmented cultural change As 'new staff knew no differently', cultural change began to be 'bedded down' and self-perpetuating.
Broadly-based community and stakeholder reference group – including Queenslan Health, MHS, mental health non-government organisations, CAMHS, Child Safety, SAAP services, Housing, Community Services, Disability Services, Aboriginal and Torres Strait Islander Services, Employment, Centrelink etc.	Guidance on working with people with mental illness and comorbidity Improved working relationships and partnerships Improved referral pathways led to organisations being more connected to other organisations and service systems; began to break down silo approach Collaborative case management process went hand-in-hand with interdisciplinary learning and multidisciplinary teamwork Redesign of intake process supported move toward an organisational culture inclusive of comorbidity
Greater program evaluation – ISI funding provided increased capacity for program review, research of the evidence, identification of best or promising practice, refinement or redevelopment of programs as well as development of new programs	Evaluation associated with a sense of achievement as well as increased professionalism

Inventory 2: Organisational Change Strategies and Processes	
Change strategy and process	Outcomes and benefits for cultural change
Comorbidity intranet portal and resources	Supported knowledge development of best practice around comorbidity – improved service to clients Brought external expertise and evidence-based knowledge to the desks of staff – increased confidence which in turn led to improved outcomes and greater ownership of cultural change Assisted staff to find their own solutions Positive feedback from other organisations promoted sense of pride in achievement and increased ownership

Inventory 3: Client Assessment and Cultural Change

Inventory 3: Client Assessment and Cultural Change		
Client Assessment Tool, Process and Resource	How developed/Provider / Source	Key outcomes and benefits for cultural change
Audit of all assessment and psychometric tools – to determine their responsiveness and appropriateness for clients with comorbidity and to identify changes required and gaps	Internally by Project Coordinator	More appropriate tools led to improved assessment
New electronic client information and service databases: for example - **Episode Tracker** – electronic client information database. The system is designed so that all MH assessments and checks must be completed before the worker is able to progress to the next stages. Treatment Plans are being added with a similar range of phased prompts. MiMaso – My management Solution – electronic, intranet-based client information management system (highly user friendly – stickman)	Supported by the CEO, the Project coordinator and key managers led the process. External consultant engaged to develop system and assist with implementation. Project Coordinator coordinated the sourcing or provision of training in psychological assessments, tools and screens that were needed.	Implementation of the new database required the implementation of evidence-based assessment processes, screens and tools which in turn led to improved assessment, better targeted intervention, better service plans and provided the information required for improved case management and referral Comprehensive mental health assessment is now completed for all clients -'fundamentally transformed of our assessment process and our practice' Assessments now systematic, consistent, comprehensive and recorded electronically Introduction of new system doubled as an education process More comprehensive client records A key contributor of shifting to a more professional culture

Inventory 3: Client Assessment and Cultural Change		
Client Assessment Tool, Process and Resource	How developed/Provider / Source	Key outcomes and benefits for cultural change
Requirement of assessment for every client	Management mandated; a requirement of accreditation; introduction supported by Project Coordinator; new assessment systems, processes and tools in some instances internally created; in others, external consultants assisted. In most agencies, a working group was formed to oversee the process.	Comorbidity increasingly systematically identified and responded to in a timely evidence-based manner as core business. Improved assessment of client needs that led to improved client outcomes as clients were receiving services relevant and appropriate to their needs Assessment process provided structure and mechanisms for client participation in the identification of their needs and preferences and in their own service plans; greater client participation led to greater empowerment and engagement that in turn assisted to improve outcomes; in some instances broke down the 'us' and 'them' approach and barriers; fostered a more welcoming culture. Improved practice as training included assessment processes, skills, tools and instruments Increased compliance with benchmarks, accreditation requirements and national standards

Inventory 3: Client Assessment and Cultural Change		
Client Assessment Tool, Process and Resource	How developed/Provider / Source	Key outcomes and benefits for cultural change
Introduction of a comprehensive range of psychological/mental health assessment and screening tools & checks – Assessment Packages - Assessment Tools Package Systems introduced including Psycheck, SOCRATES Redesigned eligibility screens Mental Health General Screen, mental Health Examination, BEC (pre and post measure of depression), DASS (Depression Anxiety Stress Scales, BIA (Activity Based Assessment), K10, Satisfaction with Life Scale, Quality of Life Scale, Mindfulness Self Efficacy Scale, NEO (personality trait), Camberwell Assessment of Need (Short Version Multiple/Complex Needs) Self Harm Screens and User Guides Risk Assessment tool and User Guide Case formulation tools and resources e.g. assessment tools, templates for case notes, case formulation, case management plans, checklists etc. Self-paced learning package on use of the assessment tools to ensure that the use of the tools remain consistent in the longer term	Management mandated; a requirement of accreditation; introduction supported by Project Coordinator; new assessment systems, processes and tools in some instances internally created; in others, external consultants assisted. In most agencies, a working group was formed to oversee the process.	Clients appropriately and consistently screened and assessed for drug and alcohol and mental health issues; increased quality of care and treatment; improved outcomes; more professional culture. The accompanying training provided with the introduction and implementation of these new systems and tools, helped to allay the fears and concerns of staff; significantly increased knowledge and confidence as well as significantly increased skills. The introduction and implementation of new systems and tools also increased the organisation's level of pride in itself. The interest and positive feedback of external agencies led to a greater sense of pride and increased ownership of and commitment to change.

Inventory 3: Client Assessment and Cultural Change		
Client Assessment Tool, Process and Resource	How developed/Provider / Source	Key outcomes and benefits for cultural change
Assessment tools for complex needs – Comprehensive Needs Assessment for clients needing multiple supports from a number of internal programs and a number of external programs	Either internally or with the assistance of external consultants. An internally working group generally guided and oversaw the process.	Increased confidence of staff in their capacity to assess and work with people with complex needs. People seeking assistance from services are systematically screened for mental illness and problematic substance use using an accepted screening approach and approach that is suited and responsive to complex needs Increased exposure of staff to working with other organisations. Increased level of interdisciplinary interaction and multidisciplinary teamwork Significant interchange of knowledge and expertise between agencies and new partners Spontaneous spawning of further collaboration and joint activity
Client outcome measurement and reporting	Either internally or with the assistance of external consultants.	Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed More outcome focussed practice has been hand in hand with staff up-skilling and a more professional organisational culture Improved client outcomes Increased staff satisfaction because they can see improvements in client's lives

Inventory 4: Practice Development and Cultural Change

Inventory 4: Practice Development and Cultural Change		
Practice development process & resources	How developed/Provider / Source	Key outcomes & benefits for cultural change
Reflective Practice initiatives in the treatment of co-occurring mental health substance use concerns **Professional Development Journal** – comprising professional development goals and logbook; supervision; and reflective journal	Internally developed following extensive research	Contributed to improved service and treatment outcomes, staff feeling more supported; greater staff satisfaction – felt supported in their professional development and greater clarity about their roles and the organisation's requirements and expectations
Clinical Review Evaluation Working Group – Comprised the ISI Project Coordinator, program managers and external experts. It acted as reference group for overseeing and reviewing practice and program change including external experts. Any member of staff could discuss with the working group an idea for improving practice, client outcomes and service delivery and the evidence supporting the idea. The working group members provided feedback that was then discussed internally. If necessary changes were made or the idea was further developed and then further discussion between the working group members and staff; when developed and refined sufficiently the idea was introduced, implemented and reviewed.	Internally developed by the ISI Project Coordinator with support of CEO	Validated our directions and practice changes Achieved and increased staff buy-in and ownership of directions and cultural changes. 'Lifted the lid internally' and gave staff a vehicle to use their expertise and to innovate and then have their ideas validated by experts in the field. By linking staff to experts in the field there was a knowledge transfer that helped to address fears about working with comorbidity and reduce stigmatising perceptions and beliefs. The involvement of external experts increased the confidence of staff in their ability to work with comorbidity safely and effectively.
Professional practice audit	Some were developed internally by the Project Coordinator whilst others were developed with the assistance of an external consultant. Most were adapted from existing relevant tools. In some instances, an internal working group developed the tool together and then refined it following a pilot with a program or team.	Provided a benchmark and directions for professional development

Inventory 4: Practice Development and Cultural Change		
Practice development process & resources	How developed/Provider / Source	Key outcomes & benefits for cultural change
Introduction of core skill requirements for staff	Management mandated as a result of benchmarking and to increase organisation's consistency with national standards and accreditation frameworks.	Promoted a learning culture and increased professionalism and practice standards. Shared understanding and expectations concerning what it means to be comorbidity/dual diagnosis capable e.g. able to screen for dual diagnosis; where indicated, conduct a more detailed assessment that enables the development of an integrated treatment and care plan; and be aware of and able to use agreed referral pathways within and between services in order to provide a seamless service for dual diagnosis clients.
Appointment of clinicians to management and supervisory positions	Need for clinicians on staff and on-site identified internally	Increased confidence among program staff that they could work effectively with people with comorbidity and their more complex needs Better supervision helped staff to feel more supported and signalled that the organisation took seriously and valued their ongoing professional development.
Use of PDACT Cycle – plan-do-check-act - employed the plan–do–check–act cycle (PDAC), started with common therapeutic AOD practice issues and then slowly increased emphasis and focus on working with people with comorbidity and coupled this with mental health training and the introduction of mental health resources	Internally facilitated by Project Coordinator with support from program managers and team leaders	Increased organisational buy-in and ownership of cultural change by providing staff with a voice and a process for both discussing their concerns as well as contributing their knowledge, experience and ideas for improving practice, programs and outcomes.

Inventory 4: Practice Development and Cultural Change		
Practice development process & resources	How developed/Provider / Source	Key outcomes & benefits for cultural change
Workshopping of texts and resources by theorists and expert professionals with whom AOD staff are familiar	Project Coordinator conducted research and prepared synopses e.g. – George de Leon's handbook – Therapeutic Community: Theory, Model and Method and his text Therapeutic Communities: Research and Application which outlines the applicability of Therapeutic Communities service models to special population groups including people with mental illness and comorbidity (also De Leon, G 2005, 'The Addiction Therapeutic Communities for Psychiatric Disorders' Therapeutic Communities, Vol. 26, no. 4, pp. 505-422)	Built on pre-existing training and knowledge of staff. Using these texts assisted staff understanding of the applicability and utility of a therapeutic community service models to the needs of comorbid clients became clear – reduced sense of cultural discordance and distance.
College of Counsellors - a weekly staff meeting that was rebadged to draw on the expertise, experience and ideas of staff in relation to working with people mental illness and the range of practice issues and challenges that emerge. Were able to discuss the implications of the needs of people with mental illness for what staff did and how programs were run.	Internally developed	Safe and supportive learning environment Integrated practice skill sets
Systems of clinical governance - Clinical Governance Advisory Committee – comprised Project Coordinator, organisational managers and program managers Clinical governance models incorporating aspects of staff training and professional development, infrastructure and resources, risk management, standards of service, staff qualifications, leadership, performance measures, systems and accountability Documentation of service models, treatments and interventions and programs and their clinical governance - (Program manuals, Staff Workbooks, Client Workbooks and reflective journals)	Generally developed internally; in some instances with external assistance.	Improved quality of client outcomes Improved safety of treatment, care and services More inclusive culture Higher level of accountability and professionalism among staff

Inventory 4: Practice Development and Cultural Change		
Practice development process & resources	How developed/Provider / Source	Key outcomes & benefits for cultural change
Requirement for and resourcing of both internal and external professional supervision	Different methods and provisions - discuss	Increased professionalism Increased staff satisfaction
Supervision training for managers and supervisors	Sourced by Project Coordinator – generally provided externally and off-site	As program managers increased their supervision skills through training they became more enabling and supportive of staff i.e. became better managers and were able to assist manage the cultural change processes; fostered a learning culture; flow on effect to staff as they felt more supported and safer in their roles; flow on effect to quality of service provided to clients and resulting in improved client outcomes
Professional Boundaries training	External in most cases; internally developed in some.	Improved knowledge about appropriate professional boundaries in interacting with dual diagnosis clients

Inventory 5: Improved Client Services and Cultural Change

Inventory 5: Improved Client Services and Cultural Change		
Client Service Improvement	**How developed/Provider / Source**	**Key outcomes & benefits for cultural change**
Dual Diagnosis No Wrong Door Protocol - guidebook for agencies and their staff in relation to how to deliver a No Wrong Door service and how to work with neighbouring agencies within a seamless and integrated service system. The protocol was often used alongside an number of resources or guides for multi-agency collaboration and for assessing/auditing partnerships	Agencies adopted and/or adapted the Protocol and Guidebook produced by the Victorian Eastern Hume Dual Diagnosis Service	Broke down isolation of a program/agency and the tradition or tendency of operating in a silo and separately from other agencies and services Agency ownership and acknowledgement that it is their responsibility to navigate and negotiate the web of health and community providers on behalf of the client and ensure seamless service between agency to agency. Over time led to an agency not turning away people with mental illness and other needs in addition to AOD issues because staff knew they didn't have to meet a person's needs single-handedly Provided agencies with a blueprint that enabled them to take the lead in approaching and engaging other agencies
Sustaining the moment: embedding dual diagnosis practice in organisation, a validated tool, clinician-oriented guidelines and auditing procedures	Developed by the NHS and the Victorian Dual Diagnosis Initiative	Benchmark of progress; supported a cycle of quality improvement and ongoing development; acknowledgment that development needs to be informed by recognition of systemic, agency and clinician-level barriers to more effective treatment of co-occurring disorders. Agency's preferred tools and approaches to be written into Intake and assessment documentation suites; agency screening protocol/ policy; and staff orientation manuals and processes.
Case management committee – oversight of development of new P&Ps, processes, tools and resources for case management, service and treatment planning and coordination.	Internally developed by Project Coordinator	Improved treatment and service planning Increased collaboration both within the agency and its own programs and with other agencies More holistic and wrap-around service provision
A new position of Family Worker – the establishment of this position enabled the development of a new clinical pathway whereby each client has family screen and a family support plan developed.	Introduced internally with support of CEO	This initiative has improved service outcomes because of a focus on addressing the high level of disconnection from family and children that is often experienced by people with AOD issues and comorbidity. Helped to address important contextual factors of day-to-day life that can influence service outcomes.

Inventory 5: Improved Client Services and Cultural Change		
Client Service Improvement	**How developed/Provider / Source**	**Key outcomes & benefits for cultural change**
Appointment of Clinical Director or Service Manager	Internally recognised need or recognised in process of evaluation	Increased staff confidence in their capacity to work with people with comorbidity and more complex needs Supported and encouraged professional development Significant on-the-job training and learning Fostered and promoted greater teamwork and collaborative practice Fostered and promoted interdisciplinary and multidisciplinary teamwork
Redesign of programs in line with strengths-based and recovery-based approaches	At times internally; and at other times with the assistance of an external consultant	Program intake and assessment approaches promote integrated dual diagnosis treatment and recovery programs as core aspects of service, including case management practices, and document interventions and outcomes in individual management plans. Treatment, care and psychosocial support more aligned with best available evidence and national and international standards and guidelines. Recovery programs and models of psychiatric disability rehabilitation and support integrated with service responses for people with alcohol and drug related problems. Promotion of a culture centred on the concept of recovery as an ongoing process of empowerment and positive life engagement
Risk assessment, contingency planning and risk management P&Ps, systems and training	Generally internally developed with guidance and oversight from a specifically constituted working group/committee; in some instances with the assistance of an external consultant	Increased confidence of staff and improved safety of care; Increased clients sense of safety and improved client outcomes Increased the level of complexity of client need that could be addressed safely, appropriately and well A key factor in shifting to a more professional culture and to an organisational culture inclusive of comorbidity, complexity and mental illness
Development of a multidisciplinary team approach	Internally or with assistance and guidance from an external consultant Accompanying training programs both onsite and offsite Reinforced in course work undertaken for Certificate IV training	Greater level of confidence More holistic programs Better client outcomes

Inventory 5: Improved Client Services and Cultural Change		
Client Service Improvement	How developed/Provider / Source	Key outcomes & benefits for cultural change
Introduction of a practice nurse/nurse practitioner – salaried position to provide general health screening, assist with medication management, work with GP to address health care needs and to initiate Complex Care Plans and/or Mental Health Plans and form working relationships with other health and mental health services and providers	Identified internally and/or as result of evaluation	Increased confidence of staff Better management of medications Addressing of backlog of health problems led to improved health and mental health outcomes Improved quality of life Stronger engagement in treatment plans
Sourcing and introduction primary health care, psychological and other mental health care services, therapies and treatments - onsite or in close proximity – list professionals; utilising Medicare/PBS based relate provisions e.g. Better Access to Mental Health Care, Complex Care Plans, Mental Health nurse initiative, / general health check, sexual health, clinics for skin, eye, ear and diabetes, medication management	Different mix of approaches and models – medical centre; onsite and sessional provided by visiting qualified professionals; onsite provided by professionals in training; coordinated offsite network In one instance, a service agreement was established between Queensland Health and ISI agency whereby eight Queensland Health clinicians have been taken off-line one day a week for 12 months to jointly conduct a DBT program onsite at the ISI Agency	Better capacity for providing effective service responses to people with AOD and mental health issues Better capacity to provide effective service responses to people with complex needs Addressed backlog health care needs Exchange of knowledge and skills between service providers Breakdown barriers and stigma in relation to mental illness and working with comorbid clients Increased level of confidence of staff Increased capacity to provide effective responses to higher levels of complexity Supported shift to more professional culture Supported shift to more holistic practice
Formation of working relationships and service agreements with professional associations and universities to enable internships and professional training placements e.g. – RANCZP, Australian College of Applied Psychology	Internally developed by Project Coordinators	Up-skilling increased range and quality of services that could be provided/offered Greater responsiveness to families and significant others of people with comorbidity A key factor in shifting to a more professional culture and to an organisational culture inclusive of comorbidity, complexity and mental illness

Inventory 5: Improved Client Services and Cultural Change		
Client Service Improvement	How developed/Provider / Source	Key outcomes & benefits for cultural change
Co-location of other services e.g. Early Psychosis	A result of service partnerships and of external recognition of improved service, improved client outcomes and greater client engagement	Reduction in service barriers and more timely access to specialist services Stronger working relationships led to increased program staff confidence Significant shared learning, exchange of knowledge and skill transfer
Formation of a DBT Reference Group and similar groups to oversee the introduction of new therapies, treatments and programs	Generally in partnership with a number of external organisations	Expansion of suite of services and treatments offered Increased clinical relevance and effectiveness Increased professionalism More open and inclusive organisations
Introduction of therapies and therapeutic programs – e.g. DBT, DBT Group Program, CBT, Mindfulness, Mindfulness based Relapse Prevention (MBR prevention), Managing Anxiety, Managing Depression, Psychoeducation and skills programs (e.g. management of medication, assertiveness, anger management, conflict resolution etc.),	Internally as well as in partnership with a number of external organisations	Programs shift to being evidence-based and therapy-based Extensive staff training and up-skilling increased range and quality of services that could be provided/offered Programs could be offered to people on waiting list for residential programs – increased engagement
Dual Diagnosis Treatment Package – redesign and redevelopment of existing treatment package to ensure interventions meet the needs of clients with comorbidity	Coordinated by Project Coordinator who engaged an external consultant to assist with the treatment package redevelopment	Where indicated, clients receive a full dual diagnosis assessment resulting in integrated assessment, better-targeted treatment and improved recovery that are documented in an individual treatment and care plan.
Drug and Alcohol Therapeutic Program. The program contains a 20 module best practice therapeutic program framed around three intervention components including life skills, cognitive behavioural therapy and drug and alcohol information and education	Built on existing program and redeveloped after an extensive review of best practice material and evidence based interventions,	Programs better aligned with best practice and evidence
Intervention Tool Kit – manual of different evidence-based interventions and programs	Internally developed	Staff access to information about evidence-based interventions made easy; increased staff confidence

Inventory 5: Improved Client Services and Cultural Change		
Client Service Improvement	How developed/Provider / Source	Key outcomes & benefits for cultural change
Strengthening Families for Comorbidity – redevelopment of parenting programs and development of a group-based program for significant others (SOS)	Coordinated by Project Coordinator who engaged an external consultant; extensive research to ensure evidence-base and/or validated; extensive consultation with peers and clients.	Greater responsiveness to families and significant others of people with comorbidity Clear message to clients and their families that agency is comorbidity 'friendly' and inclusive Supporting improvement in client outcomes Strengthening of family inclusive culture
Policy and procedure for child safety	Generally developed by an external consultant	Addressed an often neglected area Safer practice and safer programs
Treatment Counselling Program – new program evidence-based and designed for counselling in the context of comorbidity	Coordinated by Project Coordinator who engaged an external consultant; extensive consultation with peers and clients	Improved suite of treatment of services Improved client outcomes Greater staff satisfaction Greater confidence among staff to be involved with further new service developments
System for medication management and storage	Internally developed or developed in consultation with a nurse practitioner	Improved safety and reduction of risk
ISI Progress Audit cycle - audit of client files, focus groups with staff and clients, participant observation – charted progress and provided written feedback to programs and staff – cycle of quality improvement	Internally developed	Embedding of comorbidity targets within quality improvement cycle
Client's rights and participation Client voice pathways	Internally developed	Respectful culture Shift to strengths-based philosophy Greater sense of organisational accountability as well as individual practitioner accountability Mechanisms established for the involvement of clients, families and carers in the planning, review and ongoing development of services

Inventory 6: Case Management and Care Co-ordination Initiatives and Resources and Cultural Change

Inventory 6: Case Management and Care Co-ordination Initiatives and Resources and Cultural Change		
Care Co-ordination Process, Resource & Initiative	How developed/Provider/Source	Key outcomes & benefits for cultural change
Tools for case management and care coordination internally – e.g. Case-Conferencing Tool – incorporating comorbidity and comprising treatment plan, treatment planning processes and case conference and review processes; Care Collaboration Process Package	Developed internally by Project Coordinator in consultation and collaboration with managers and staff Care Collaboration Process Package developed internally by an ISI agency - collaborative effort by staff through workshops, drafting, role-plays and testing.	Better structuring and planning of service delivery and support. Increased capacity to work with the more complex needs of clients with comorbidity Increased confidence of staff in working with clients with comorbidity Greater knowledge between different teams and programs of who is involved with a client, what is being done by whom and when; what outcomes are being sought; and what progress is being made
Inter-agency collaborative case management and care coordination processes - Complex Care Panel; Complex Case management; Care Collaboration Process Package includes forms, templates for meeting agenda, minutes, Action Plan, call out across teams, clients involved at the collaborate care meeting or else meeting with key worker beforehand	Bedded down internally, tested and adapted/expanded for use externally in collaboration with other agencies.	Better outcomes for complex issues internally and externally; Improved relationships with referral partners particularly mental health; Improved processes for the involvement of other services and other professionals; Improved risk assessment; Improved management and communication of client information; Improved movement of clients in and out of mental health services; Improved sourcing of mental health information prior to client arrival
Relapse prevention planning	Internally developed following research and discussion with other organisations	More comprehensive treatment planning
Improved knowledge of avenues and referral pathways for dual diagnosis	External provider – Smart Recovery	Improved knowledge of avenues and referral pathways for dual diagnosis

Inventory 6: Case Management and Care Co-ordination Initiatives and Resources and Cultural Change		
Care Co-ordination Process, Resource & Initiative	How developed/Provider/Source	Key outcomes & benefits for cultural change
Local/regional comorbidity forums & networks - Cairns and Hinterland Dual Diagnosis Forum meets monthly and provides a platform for discussion, resource sharing, problem solving and project implementation to better coordinate service delivery for people with comorbidity and to develop and sustain local inter-sectoral and multi agency collaboration; Heads Up – Gold Coast Network of Agencies working with MH and AOD comorbidity –.	Internally and in partnership with other organisations	More outward looking in approach Increased collaboration and increased interdisciplinary practice Problem solving to address service access difficulties that in turn led to increased service access Collaboration to address service and treatment gaps – more comprehensive services locally and regionally

Inventory 7: Training and Workforce Development and Cultural Changes

Inventory 7: Training and Workforce Development and Cultural Changes		
Training & workforce development Initiatives & Resources	How developed/Provider/Source	Key outcomes & benefits for cultural change
CPI Training (non-violent Crisis Prevention Intervention	In some instances existing training materials/programs were adapted and presented by the Project Coordinator; in other instances an external provider or trainer provided training.	Significant increase in staff confidence as result of increased knowledge and increased practice skill set Increased responsiveness to working with people with comorbidity
ASSIST Suicide Prevention and other suicide prevention training	Generally provided by an external provider; in some instances train-the-trainer courses were conducted by already trained staff.	Improved skill in identification of self-harm behaviours and suicide
Relapse Prevention for working with comorbidity in the AOD sector	Internally developed by an interested member of staff – adapted the ASSIST relapse prevention model	Improved relapse prevention understanding and skill Increased number of staff who engage clients in relapse prevention planning and skill development
Certificate IV level training - in Mental Health; AOD; Community Services Diploma level training – Combined Mental Health and AOD; Community Services Management; Counselling Post-graduate training – e.g. Project Management, Masters	Different approaches – e.g. existing RTO – developed own programs; partnered with RTO to deliver training onsite; sourced scholarships or free or reduced price training places; development of intranet resources to support staff to undertake the training	Increased levels of comorbidity competency Increased willingness and enthusiasm for working with people with comorbidity Greater understanding and education around alcohol and drug disorders and mental illness symptoms, management and treatment interventions – improved service for comorbid clients Up skilling of staff, Improved retention of staff and reduced staff turnover
Facilitation of Clinical Case Conferencing training	External provider; attended by Project Coordinator at times, key team leaders/mangers.	Better treatment planning More integrated and coordinated service delivery as a result of increased skills in care coordination
Training for managers - Professional Development program for managers, coordinators, senior clinicians/practitioners; Change Management	External providers including Australian Institute of Management, ATI Mirage	Better management of services which leads to improved client outcomes

Inventory 7: Training and Workforce Development and Cultural Changes		
Training & workforce development Initiatives & Resources	How developed/Provider/Source	Key outcomes & benefits for cultural change
Workplace Practice Questionnaire for AOD (WPQ) – slightly adapted for use in comorbidity practice setting	Adaptation of pre-existing validated tool. Internally facilitated by Project Coordinator.	Subsequent applications of the WPQ (e.g. three-four cycles) showed increased confidence of staff in their practice with clients with comorbidity and improved attitude toward working with comorbidity.
Skill and practice audit	At times internally developed at other times adapted from an existing tool/resource	Benchmark for planning and sourcing staff training
Training needs analysis	At times internally developed, at other times adapted from an existing tool/resource	Benchmark for planning and sourcing staff training Provided documented and objective evidence for the need for investment in training and professional development
Mental health related and other training – MHFA, Nuts and bolts of Psychiatry, Psychiatric Medications and Medication Management, Development throughout Life Span, Recovery-based practice	Sourced from external providers	Greater understanding and education around mental illness symptoms, management and treatment interventions – improved service for comorbid clients Knowledge of the principles associated with assisting clients to take their medication – increased confidence in assisting clients to manage their medications – increased support to clients to continue with their medication – improved mental health outcomes
Training in psychological therapies, interventions and frameworks – e.g. CBT, Dialectal Behaviour Therapy, ACT, CBT, DBT, Early Psychosis Intervention and Recovery, Relapse Prevention Planning, Therapeutic relationships, Strengths-based Practice	Sourced from external providers Some training provided in-house In one instance, Queensland Health jointly funded a weeklong DBT training course for staff of one of the ISI agencies.	Knowledge of and expertise in a range of therapeutic techniques for use with clients with comorbidity
Division of General Practice Dual Diagnosis training - Dual diagnosis 'Can do' workshops; 'Can do' Workshop amphetamine and psychosis	Provided by Division of General practices	Improved staff knowledge and skills for working with comorbid clients
Training in working with specific comorbid groups - Working with Borderline Personality Disorder; Sexuality and Gender Identity Awareness training; Trauma and Substance Abuse Treatment	Generally sourced from external providers	Improved knowledge and skill in working with a comorbid client group – particularly in respect to boundaries, transference and counter transference Skilled staff in the delivery of PTSD intervention and identification -Improved interventions for comorbid clients

Inventory 7: Training and Workforce Development and Cultural Changes		
Training & workforce development Initiatives & Resources	How developed/Provider/Source	Key outcomes & benefits for cultural change
AOD related training - Identifying and managing challenging behaviour, self harm and motivational interviewing techniques; drug and alcohol and challenging behaviour	At times provided in-house but generally sourced from external providers	Improved knowledge and skill in working with a comorbid client group Ability to use therapeutic techniques for the benefit of clients with dual diagnosis
Peer workforce development – e.g. Peer Leadership Program - run over two days (four hours) and is free. Comprises dual diagnosis (MH & D&A), relationships, counseling, anger management, communication. It is facilitated and experientially based. Produced as marketable resource and could be adapted for volunteers and new staff.	Developed internally	Engagement and empowerment of peers
Cross-cultural training	Generally sourced from external providers	Significantly more welcoming and inclusive of people from culturally diverse backgrounds Increased cultural awareness among staff and volunteers Increased cultural safety and sensitivity
Training in mental health for Indigenous staff	Generally sourced from external providers	Increased confidence among Indigenous staff
Adult Survivors of Child Abuse (ASCA) training	Sourced externally	Greater awareness among staff of the incidence and impact of trauma and abuse on the lives of clients in general and more specifically on the lives of those with comorbidity
Mental health and AOD training for Aboriginal and Torres Strait Islander staff	Provided by Dr Tracy Westerman	Changes to increase the cultural safety and sensitivity of the workplace and of programs has resulted in 600% increase in Aboriginal and Torres Strait Islander staff in the ISI agency which in turn has increased the number of Indigenous clients.
Job shadowing in specialist services e.g. ATODS	Collaboration between Queensland Health and an ISI agency; and between two ISI agencies	Practice development in respect to the improved services project and improving service delivery for clients with comorbidity, developing a mentoring relationship. Practice development in respect to the ISI project and related flow on practice to staff of each agency improving service delivery for clients with comorbidity

Inventory 8: Partnerships and Cultural Change

Inventory 8: Partnerships and Cultural Change		
Strategy	Process for development	Key outcomes & benefits for cultural change
Partnership Framework	Internally	Guidance for agency and staff with partnership building Helped to shifted culture to be more outward looking and collaborative
Networking Kits – for both external and internal partners	Internally	Guidance for agency and staff with partnership building – encouraged and reminded staff of the need for collaboration and coordination
Partnership Self-Assessment Tool – a validated tool developed in Canada by Lynne Maher, Prof David Gustafson, Myson Evans	Adopted from existing resource	Enabled ISI agency to assess strengths, weaknesses and gaps in existing partnerships and to plan to address gaps and shortcomings
Heads Up: A network of agencies working with AOD and mental health comorbidity – achieved funding for a small secretariat; working parties established to work on specific issues;	Internally initiated partnership	ISI agency assumed a leadership role Significant impact on local service mix and level of service coordination and integration New services responses, treatment options and support programs 'spawned'
Partnerships with RTOs and universities	Internally initiated	Resulted in 'on-top' training opportunities for staff and volunteers Staff buy in and commitment to working with people with comorbidity Expansion of knowledge and skill base Greater professionalism Significant service and treatment development in line with evidence and best practice
Partnerships with professional associations	Internally initiated	Assisted to embed commitment to professional development within the organisation Increased management commitment to planning for and investing in professional development Horizon of staff and organisation lifted

Inventory 8: Partnerships and Cultural Change		
Strategy	Process for development	Key outcomes & benefits for cultural change
Service partnerships for one – Collaboration to address complex needs – too big for any one organisation; requires broadly-based partnership including primary health care, mental health, AOD, Family Services, Housing, SAAP, HACC, Child Safety, Disability, employment, education and training, Centrelink etc.	Local and regional partnership	From being on the outer and rarely thought of by other organisations, the ISI agency became a central player in active, results oriented partnerships Began to assume a leadership and coordinating role
Partnership 'coordinator' or liaison officer – need for ongoing role recognised as well as accompanying resource investment – dedicated staff position with hours allocated	Generally fulfilled by Project Coordinator but growing awareness that the role needs allocated time and resources	Greater connectivity with other organisations A more learning organisation that benefits from the experience, expertise and strengths of other organisations

Inventory 9: Cultural Change Pathways

Inventory 9: Cultural Change Pathways				
Watershed Pathway	Empirical and Structural Pathway	A Hearts and Minds Practice-Centred Pathway	A Community-based and Partnership Centred Pathway	A Cultural Change 'Creep' Pathway
Articulation of a turning point or new vision Board backs new directions Broadcasting of the new directions and change – internally and externally Client participation strategies Revision of corporate documentation and P&Ps Converging with QI process Change in organisational structure Strategic workforce development Extensive training opportunities Staff up-skilling Clinical leadership, clinical governance and staff supervision Setting in place necessary infrastructure e.g. assessment tools, case management and care coordination processes/tools, client information system, facilities Strategic expansion of partnerships	Analysis of the implications of Baseline Study with management Confirmation of the need for change Assembling of an evidence-base, best practice guide and relevant standards and guidelines Presentations by people with lived experience Benchmarking of P&Ps and then audit compared against the evidence base and standards Identification of organisational strengths and weakness Confirmed imperative for change Presentation of the state of play to management and staff Conversations with management about how to proceed Management formally and publicly endorsed findings and need for change Decision to rely on evidence-based, validated or best practice instruments, tools and resources endorsed by management Leveraging from external and co-	Lead and teach by doing and sharing approach favoured - establish 'street cred' Collegial group processes for discussing impact of desired change on practice and positions – allow and encourage venting – 'normalise reactions to change' Change embedding and saturating through collegial processes Converging with QI processes and cycles Link cultural, program and practice change to familiar theoretical frameworks Introduction of processes, resources and supports for practice and professional development, supervision and opportunities to contribute expertise and to purse further development in areas of professional interest/passion Extensive collective training opportunities as well as training opportunities to support the specific interests of individuals Establish processes to widen	Management endorsement of need for change but uncertain as to direction for change Stakeholder advisory processes established Appointment of a Project Coordinator to steer and manage the initiative Stakeholder consultations led to early improvements in referral pathway and an active commitment to collaborate Brainstorming internally and externally couple with research about evidence-based, best practice and cutting edge comorbidity treatments and programs for organisation's target groups Commencement of quality improvement accreditation process Ideas firm as to the type and nature of desired change and the type of service improvements sought Vision emerging as to where the organisation could head and what it could become	A realisation by management that change was needed and that project could help resource that change PC and Manager working closely together and sharing enthusiasm for the project An early focus on Involving and engaging staff Not trying to change too much too quickly – starting with one program stream and later bringing on-board other streams and at this later point responsibly for coordination of project being shared across programs Staff participation in and contribution to the embedding and weaving of comorbidity in corporate documentation - new P&Ps drafted, workshopped and finalised with staff and then induction Saturating the workforce with mental heath and comorbidity information and training relevant to the issues they were experiencing in their jobs Working alongside staff and

Inventory 9: Cultural Change Pathways				
Watershed Pathway	Empirical and Structural Pathway	A Hearts and Minds Practice-Centred Pathway	A Community-based and Partnership Centred Pathway	A Cultural Change 'Creep' Pathway
Program and service development	occurring events – e.g. signing of new contracts & QI process Identification of champions and those who were opposed Training and up-skilling– ongoing audited and evaluated Partnership audit initially and then focused on building strategically necessary and helpful partnerships Rewriting of P&Ps based on evidence and best practice Restructuring of programs & positions based on evidence and best practice Employment team leaders and program staff with relevant clinical/practice experience Redesigned programs based on evidence and inclusive of comorbidity Stronger program/clinical governance - (Program manuals, Staff Workbooks, Client Workbooks & reflective journals); Developing of d new evidence-based or best practice-based programs Introduction of a new client assessment and service delivery information system and	horizons by linking staff to external experts Establishing processes to encourage staff creativity and input and to have their ideas refined and validated by both management and external experts Introduce new P&Ps, new assessment, treatment planning, care conferencing and client info systems in away which doubles as education and professional development	Partnerships assist with training and up-skilling of staff and work collaboratively to introduce new programs and treatments onsite Extensive training opportunities are sourced and emerge for staff Introduce new P&Ps, new assessment, treatment planning, care conferencing and client info systems in away which doubles as education and professional development for staff Local collaboration leads to further new service models Changed office, atmosphere, intake procedures and forms to be more welcoming of complex need and more culturally safe and sensitive Agency becomes a hub in the local community for comprehensive and holistic collaborative care and service responses	problem solving together – asking staff a lot of what do you think questions Focus on internal relationship and internal processes and creating opportunities for staff to vent and learn form each other Helping staff to understand the workplace cultures and requirements of health and mental heath services – reducing the cultural distance Focus on engaging staff in QI Focus on involving staff in networking and building external relationships Extensive training opportunities – including undertaking of formal qualifications free of charge for both staff and volunteers New database – electronic records progressively rolled out Greater internal communication and collaboration between different programs and teams Celebrating progress, achievements and improved services and client outcomes

Inventory 9: Cultural Change Pathways					
Watershed Pathway	Empirical and Structural Pathway	A Hearts and Minds Practice-Centred Pathway	A Community-based and Partnership Centred Pathway	A Cultural Change 'Creep' Pathway	
	outcome and performance measures				

Inventory 10: Sustaining the Change and Strategies for Cultural Change Initiatives

Inventory 10: Sustaining the change and strategies for cultural change initiatives		
Strategy	**Process for development**	**Key outcomes & benefits for cultural change**
Continuing mental health comorbidity training – e.g. Advanced training in comorbidity typologies and specialised programs, treatment and interventions Training in working with psychosis and acute mental illness	Some in-house but generally sourced from private providers Placed on agenda by ISI agencies for discussion with QNADA about sustainability into the future	Ongoing development of expertise – not becoming complacent
Collaborative scoping of the project and pre-project planning with the sector – collective wisdom re this is where we are at, this is what the project is about, this is how it could benefit us collectively and individually	Placed on agenda by ISI agencies for discussion and collaborative development with QNADA	Better project beginnings Efficient use of resources Strengthened products and processes by harnessing of collective expertise and experience as against an individual project coordinator working alone
Communities of practice – extended to three levels – DOHA and Peaks, Peak and agencies; and networked agencies	Placed on agenda by ISI agencies for discussion and collaborative development with QNADA	Emphasis on practice development and workforce development from outset and throughout project
College of advisers (experts in advisory capacity)	Internally developed	Emphasis on practice development from the outset and of drawing on the expertise and knowledge of staff – promote ownership
Engage and inform Boards	Placed on agenda by ISI agencies for discussion and collaborative development with QNADA	Support for management to commit to and drive change from the outset Enable Boars to keep up-to-date with progress, challenges, problems and learning and promote collective and corporate celebration of achievements as well as sense of ownership of solutions
Sector workforce mapping and training needs analysis	Placed on agenda by ISI agencies for discussion and collaborative development with QNADA	Benchmark for moving forward
Project Portal and e-Resources-	In train and placed on agenda by ISI agencies for discussion and collaborative development with QNADA	Efficient processes for development and sharing of resources Reduction in duplication of effort More targeted and integrated use of resources – e.g. staff, funds

Inventory 10: Sustaining the change and strategies for cultural change initiatives		
Strategy	Process for development	Key outcomes & benefits for cultural change
e-Training and eLearning	In train and placed on agenda for by ISI agencies for discussion with QNADA and further development - collaborative	Efficient processes for development and sharing of training resources Reduction in duplication of effort in relation to online training More targeted, consistent and integrated use of online training resources
Sector development focus	Strengthened during ISI program	ISI gains to be translated across the sector i.e. inclusiveness of and competency with comorbidity shifted beyond the 12 participating agencies
Casual staff pool	In train and paced on agenda by ISI agencies for discussion with QNADA and further development – collaborative	Enable projects to commence on time Reduce impact of turnover Benefits from a more diverse workforce
Networked comorbidity and primary health care arrangements	Internally and with partnerships	Formalisation of arrangements could duplicate the health benefits and recovery gains to other locations throughout the state
Engaging the professional associations-	Initiated internally but would result in significant gains if arrangements and partnerships formalised by QNADA into a state-wide focus	Assist to embed commitment to professional development within the organisation Increase management commitment to planning for and investing in professional development Lift horizons of staff and organisations
Interagency shared clinical governance	Internally initiated Models could be evaluated and written up as a sector wide resource and guide	Translation of gains in professionalism, safety and risk management to the sector as a whole
Interagency staff secondments for training placements	Internally initiated Arrangements could be further developed and formalised by QNADA – state-wide focus	Support professional and workforce development throughout the sector
Webinar-based practice development program with interstate and international experts – e.g. Kevin Minkoff - treatment and care models for typologies of comorbidity – CDP points	Placed on agenda by ISI agencies for discussion with QNADA and further development – collaborative	Ongoing development of the range of treatment options as well as ongoing expansion of workforce skills, expertise and practice sets
A training calendar - inclusive of conferences, webinars, lunch time seminars, conferences etc.	In train and placed on agenda by ISI agencies for discussion with QNADA and further development – collaborative	Ongoing professional and workforce development – working against complacency and glass ceilings

Part Four: Learning about achieving and sustaining cultural change

Part Four of the Report outlines some of the lessons learned by the ISI agencies for achieving and sustaining cultural change:

- What worked well;
- Key enablers of cultural change;
- Major barriers and obstacles;
- What didn't work and what might have been done differently;
- Turning points;
- Sustainability of the change; and
- Unfinished work.

There follows a discussion on ways in which the learning and experience from this project can be taken forward into future alcohol and drug sector cultural changes in Queensland. This includes the utility of the project, the roles that were new and/or difficult for the project staff, the aspects of the project that project staff enjoyed most, and what additional support would have been beneficial.

Finally there are a range of suggestions for the key stakeholders in the ISI Project, namely DOHA and QNADA.

Learning about achieving and sustaining cultural change

This section outlines some of the lessons learned by the ISI agencies for achieving and sustaining cultural change:

- What worked well;
- Key enablers of cultural change;
- Major barriers and obstacles;
- What didn't work and what might have been done differently;
- Turning points;
- Sustainability of the change; and
- Unfinished work.

What worked well

It is important to note that though what worked well differed between agencies there were also a number of common themes that are outlined below.

Opportunities for training and up-skilling

Opportunities for training that led to formal qualifications or enabled staff to develop their repertoire of practice and clinical skills not only assisted to improve practice and services but also increased buy-in and support for the cultural change that organisations were seeking. Staff appreciated their organisation's demonstration of commitment to professional development evidenced by:

- The training and skill acquisition being free of charge;
- The training occurring onsite or in close proximity; and
- Being supported by self-paced e-learning resources.

Both staff and their organisations took pride in being able to observe improved client outcomes as a result of being able to provide more diverse and specialised treatments and programs.

Staff involvement in the change

Staff involvement in the change process and in the designing of new instruments, resource packages and treatment programs increased buy-in and resulted in the participating staff becoming champions of the desired cultural change.

Linking the change to the familiar

Project Coordinators learned that linking the desired change to theoretical frameworks or service models that staff were familiar with, because of their training or professional experience could reduce their fear of change. Supporting staff to see that the changes were consistent with what they were already doing or seeking to do also increased support for the changes.

Client involvement and guidance

Client involvement in the change processes and in the design of new programs or redesign of existing programs provided both moral support and guidance for the change. The participation of 'experts by experience' provided a reality check and a barometer indicating whether the

changes being made were grounded in lived experience and would result in services that people with comorbidity wanted and would feel comfortable using.

Focus on improved outcomes

Project Coordinators noted that focusing on the organisational goal of improving client outcomes helped to reduce resistance to change as it was a positive focus as against a top down focus on skill 'deficits' and program 'inadequacies'.

Coming together with other ISI organisations

Project Coordinators reported that the National Conference and state-based forums were important not only because of the opportunities for coordinators to learn from each, to network and to share ideas but also because a message was to the ISI organisations that they were part of a bigger picture – a national initiative to improve services and lift the capacity and profile of AOD sector.

ISI Project Coordinator having clinical and management experience

Views differed among project coordinators as to the skill set required for coordinating the ISI project. Though not essential, having both relevant clinical and change management experience appeared important to managing the demanding requirements of the position. This dual experience also appeared to assist Project Coordinators to have sufficient credibility to engage both internal and external stakeholders.

This combined experience was also important in assisting Project Coordinators gain respect from and have credibility with both management and staff because they could be sensitive and supportive of staff whilst also being acutely aware of what was occurring organisationally and programmatically.

Other strategies that worked well

Other strategies that worked well reported by Project Coordinators include:

- Introducing change slowly;
- Seeding conversations with staff and volunteers;
- Progressively building the confidence of staff;
- Strategic opportunism arising from comorbidity being written into the mission statement and strategic plan
- Being able to leverage confluence of events and factors at any one point in time.

The informal collegial support between Project Coordinators was viewed as an important factor in the success of the ISI project.

Key enablers of cultural change

Some of the key enablers of cultural change identified by agencies included:

- The ISI and its funding;
- The leadership of management;
- Strengthened clinical governance;

- Multidisciplinary team environment;
- Partnerships;
- Open communication with staff;
- Engagement of champions; and
- Introduction of new systems and resources that improved safety and quality whilst also making work easier and more rewarding.

Improved Services Initiative itself and its funding

The ISI funded agencies spoke highly of the funding model of the Capacity Building Grants Program. They identified the funding model as being a key factor in their organisations' success in achieving cultural change. The enabling characteristics of the funding model singled out by agencies included the fact that it was empowering rather than prescriptive, that it was outcome-based, that it provided a level of structure through guiding frameworks, that it provided significant resources and that the funding program itself was located within a suite of complementary initiatives.

> *Strategically this has been one of the best government funding initiatives I have seen … The most effective thing about the project was that it wasn't overly prescriptive – it said here is the money and here are the broad outcomes we want – now tell us how you plan to achieve those outcomes.*

The leadership and active support of management

The mandate, auspice, leadership and active support of management were vital to organisational acceptance of the imperative for cultural change and of cultural change itself.

> *Management's mandate of cultural change is critical. We are always working hard on communicating and demonstrating it. We are constantly at it. The Board's support has been invaluable; strengthened determination of management and this belief has filtered throughout the organisation.*

Strengthened clinical governance

Strengthening clinical governance was the key to addressing the actual and perceived risks associated with working with people with more complex needs. It was critical to staff feeling safe and supported. It reassured staff that they were not working on their own and that supervision and support was at hand.

Strengthened multi-disciplinary team environment

As with the improvements to clinical governance, a strengthened multidisciplinary team environment helped to foster a culture of learning as well as increasing confidence of staff in their capacity to work with people with comorbidity and more complex needs.

The shift to more multidisciplinary team environment was frequently not easy. Managing the tensions that arose from different views, approaches, emphases and expectations of staff from a number of different disciples was a new terrain for agencies. It was also new territory for staff themselves, many of whom were used to operating alone and making decisions by themselves.

Shifting to collective decision-making and to having fellow staff members from a number of different disciplines providing their input and point of view proved frequently challenging. Working alongside volunteers and peers also proved challenging. Though challenging and difficult, the agencies reported that the shift to a more multi-disciplinary team environment was pivotal to providing a more holistic model of care.

Strengthened partnerships

Providing staff and their programs with access to the advice and support of mental health specialists through new or expanded partnerships also strengthened learning, up-skilling and confidence.

Open communication with staff

Ongoing, regular and open communication with staff promoted support for the cultural change. It was important that the communication was two ways and that staff were able to raise their concerns, vent their angst and contribute their ideas.

Engagement of staff champions

As discussed earlier, engaging champions both internally and externally assisted the promotion and wider enlistment in the change process.

Introduction of new systems and resources that improved safety and quality whilst also making work easier and more rewarding

Consistent with the tenets of Kotter's model of organisational cultural change, agencies identified the achievement of early gains and early benefits for staff and clients as enablers of further change. Early gains included the introduction of a new system and resources that addressed risk, improved services and contributed to more rewarding positions and to a more dynamic workplace. In particular case conferencing provided increased confidence and on-the-job learning.

> *What enabled the project to build up steam? When we introduced processes, tools and products that made work easier and safer and led to noticeably better outcomes for clients. For us it was our new assessment and care conferencing systems.*

The hardest things to change or most difficult tasks

Some of the hardest things to change according to Project Coordinators included changing attitudes and entrenched practices and ways of providing programs. A further frequently identified difficulty was introducing new systems, tools and programs all at once and getting the pieces to all come together.

The list of the hardest things to change identified by the agencies included the following.

- Attitudes to mental illness in a small organisation;
- Entrenched staff attitudes / beliefs (e.g. this is what is and isn't a therapeutic community is);
- The perception that working with comorbidity seen as too hard or too much extra work;
- Incorporating mental health into the assessment, treatment and planning processes and data recording and reporting;

- Formalising assessment and introducing structured treatment and interventions;
- Getting the right IT system and implementation;
- Efficiently sharing information in such a multidisciplinary system;
- Some staff philosophies around harm reduction in a comorbidity setting;
- Challenging Issues around duty of care. Some viewed it as onerous because it at times required more work;
- Reporting challenges of complex care with comorbid clients;
- Defining outcomes for comorbid clients.

Major barriers and obstacles

The three most commonly identified barriers or obstacles identified by agencies were:

- Difficulty in recruiting and retaining a Project Coordinator with the right skill set and experience;
- Releasing staff for training and funding appropriate staff to backfill positions;
- Problems associated with the funding cycle and the organisation's capacity to spend certain line items within specified timeframes of the cycles.

Lack of flexibility in how project funds came to agencies - we needed to be able to roll funds forward throughout the life of the project, especially for training which could take time to source and was not always available within timeframes of funding cycles

What didn't work and what might be done differently

Though what didn't work differed from agency to agency, some of the most commonly reported items by Project Coordinators included duplication of effort and agencies not having a mechanism to report to funders the impact on the organisation of having more complex clients and of doing harder work and to have this impact acknowledged by funders. A number of agencies reported that they had not been able to give sufficient priority to building partnerships whilst also managing the internal change processes and project implementation.

A number of agencies reported that despite their efforts they had not been successful in engaging staff of Mental Health Services who were sufficiently senior to make decisions that could have made a difference on the ground. In retrospect some suggested that it might have been more productive to have just focussed on working relationships team leaders and individual clinicians. Some agencies also reported they had not been able to develop and sustain a sufficient focus on client participation.

Turning points

Some of the most significant turning points identified by Project Coordinators were the endorsement by management of the Baseline Study's findings, the ISI project's directions, the imperative for change and a managerial declaration of confidence in the Project Coordinator. A further significant turning point following on from these was affirmation by the Board of

comorbidity as core business. This was reflected and signposted through incorporation of comorbidity into the mission statement of the agency.

Other important turning points included:

- Organisational restructure to reflect role with comorbidity;
- Reconfiguration of the position of Project Coordinator and responsibility for the project's coordination and implementation;
- Linking the ISI project with a co-occurring quality improvement accreditation process and commencing this accreditation process and consistency with standards;
- Addressing the risk associated with comorbidity and more complex needs; and
- Particular training during which staff became convinced they could work safely and effectively with people with comorbidity.

All agencies noted a shift in support for change with the commencement of the rollout of Certificate IV training programs throughout their organisations, free of charge to all interested staff.

Sustainability of the change

Many aspects of the cultural change were considered sustainable having been embedded in the organisation's mission, corporate documentation and processes. Aspects of the change that were considered to possibly not be sustainable include:

- Continuing to work with the same level of complexity without resourcing of clinical governance and clinical leadership;
- The same level of subsidised workforce development opportunities;
- Ongoing training if trained staff leave; and
- Retention of staff without parity of wages to government sector; e.g. 'we train staff up with great programs, then lose them to higher paid positions'.

Most agencies were concerned about whether they would be able to sustain a dedicated focus on partnerships with corresponding resourcing.

Some changes are sustainable and some are not as they require constant staff support. Assessment tools package has online training package developed for and takes care of itself. Appropriate staff responsible for any updates required to this. All of it is also regulated by policies and procedures.

The level of training is not going to be able to carry over as is without the project money. Working on the more sustainable options to satisfy core skills requirements and provide ongoing professional development of staff e.g. intranet-based/online.

Networking is not sustainable as it is time and resource extensive and something that an agency has to keep working at, particularly given high turnover rates in the agencies we need to work with.

Still have more work to do but training remains, new systems and resources, new P&Ps remain

Without funding for PC the networking and partnerships won't happen

Internal training packages need to be supported by external training and will require training funds

We need to look at how we make the peer leadership training sustainable and how we develop the product accordingly.

Unfinished work

Areas of unfinished work related to the ISI initiative reported by Project Coordinators include embedding comorbidity in the work of agencies throughout the alcohol and drug sector in QLD, particularly in other agencies who have not participated in the ISI program. Other areas of work thought to require a continuing focus include:

- Building on the skill, practice and program development in participating agencies;
- Auditing and benchmarking the current capacity of the whole sector to work with comorbidity and complex needs through skills and program audits and a training needs analysis.

Taking the learning forward: informing future sector-wide cultural change initiatives

This section outlines ways in which the learning and experience from this project can be taken forward into future alcohol and drug sector cultural changes in Queensland.

The utility of the project in a nutshell

The participating agencies reported that though the ISI project presented many tough challenges they would welcome a further similar initiative in the future. As discussed above, the agencies viewed the funding framework of the Capacity Building Grants Program as a potential model for future service development and reform initiatives that require a similar enabling and flexible approach.

The ISI project enabled us to consolidate our service developments, redesign some of our service models and programs, increase the evidence base of what we do and improve the administration and infrastructure that sits around service delivery – new and better frameworks, guidelines, tools, electronic client information system etc.

What roles were new and/or most difficult for project staff

Some Project Coordinators had previous clinical experience in the AOD sector and some didn't. Some had worked in mental health whilst others had experience in project management and/or change management. Few had experience with cultural change per se.

Project Coordinators reported that the roles that were new and/or most difficult for them personally included:

- Change management;
- Managing high levels of staff fear, resistance and angst;
- Management of a project within a larger organisation which sometimes had conflicting demands on resources, particularly staff time;
- Managing change across a number of programs and/or regions or states;
- The relentless workload;
- The isolation of the role and turnover of PCs in agencies;
- Rebuilding the project after a previous Project Coordinator or key staff had left;
- Being able to stay on top of all requirements of the position; and
- Doing what needed to be done whilst also communicating sufficiently with staff and external stakeholders.

What project staff enjoyed most

Overall the Project Coordinators enjoyed the challenge of the project and the sense that they were contributing to important changes that could improve outcomes for people using AOD services in Queensland. Project Coordinators also sensed that they were contributing to the development of the non-government alcohol and other drug sector in Queensland.

Seeing the change in training provided and the evolution to evidence base practice in the organisation

The challenge of getting it all done despite how frantic

Teamwork

Being able to see increased staff confidence and improved client service

Admin processes in line with accreditation requirements/modernised e.g. from cards to electronic

Stimulation of having a strategic role

Being involved with macro level and big picture change

Being involved with a statewide and national project was a buzz

Influencing change and increasing professionalism

Finding creative ways to communicate difficult things in an engaging way

I enjoyed many things – I enjoyed the challenge of creating and supporting change; enjoyed the transformative process and the contribution it made to our organisation; enjoyed the learning curve and being able to work with all staff; enjoyed networking; enjoyed seeing the products, tools and resources take shape, work and then produce better client and service outcomes; enjoyed seeing staff get excited about the resources and enjoyed seeing their pride; enjoyed the responsibility that came with the role; the project has coincided with a period of rapid development within our organisation

Seeing staff get excited about improved client outcomes and being able to effectively work with people they had previously thought were too difficult to work with

Perhaps the best moment of all was when all staff sat together in a client's commencement. This was a client with complex needs arising from Personality Disorder and was a client who we would not have previously accepted – this client who would have been excluded from eligibility for our program was now successfully entering the next phase of recovery.

What support would have benefited project staff and agencies

Project Coordinators suggested that they would have benefited from the facilitation of greater opportunities for informal collegial support and the development of mechanisms and processes for sharing of resources. In particular, agencies stressed the need for a project intranet site where resources could be pooled and shared including for example:

- Templates;
- Policies and procedures;
- Research and evidence;
- Information about the practice and 'art' of cultural change and change management;
- Program designs;
- Training packages;
- New tools and instruments;
- Lessons learned;

- Use of social media suggest as project blog for problem solving or project Twitter/Facebook site for ready communication.

A buddy up system and a resource person who could visit each agency was also suggested, as were regular teleconferences between project coordinators via Skype.

Finally an annual state conference combined with training programs was also suggested.

Taking the learning forward: suggestions for Department of Health and Ageing

A number of suggestions were made by agencies to support DOHA take forward learning from this current cultural change project. The major suggestions related to:

- The tendering process for organisations based in more than one State;
- Having consistent reporting requirements and templates;
- On the ground support and contact with project sites;
- Having the Baseline Study and other data collation tools in place from the outset;
- Annual conference or similar forum;
- Greater clarity about the role of State peaks;
- Capacity to roll-over funds within and between funding cycles;
- Acknowledging that embedding cultural change to the point of sustainability takes time.

Tendering process for organisations based in more than one State

Provision could usefully be made for a nationally-based organisation to submit a single submission for funds to conduct the project in each of the States where it has a presence.

Keeping reporting requirements and templates consistent

All of the ISI agencies noted that it would have been helpful if the funding body had not changed reporting requirements and templates. Frequent changes of staff and 'shifting the goalposts' during the project was cited as impediments to the project.

On the ground support and contact with agencies

Agencies suggested that it would be helpful to both organisations and to DOHA if the National Project Coordinator had visited agencies from time to time. In the agencies' view this would have enhanced DOHA's understanding of how the project was rolling out on the ground, the progress it was making, the obstacles or difficulties it was experiencing and the impact it was having on people's lives as well as on organisations. It would also have assisted agencies to be clearer about the expectations of DOHA. Importantly, on the ground contact with the National Project Coordinator would have promoted a sense of national partnership and would have provided a vehicle for information exchange and collaboration between jurisdictions and between organisations. Collaborative problem solving and innovation would have also been promoted.

Project Intranet Site and use of Social Media

Agencies suggested that greater use of web-based technology would have enabled a cost effective and efficient means of resource sharing between the ISI agencies throughout Australia. This was seen as a means to facilitate sharing of resources, develop common tools, collaboratively conduct research about cultural change and share best practice and evidence-based comorbidity treatments, interventions and service models.

Baseline study and other data collection tools in place from outset

As discussed, the Baseline Study came to be viewed as an important project catalyst. Agencies suggested that greater use could have been made of the BLS throughout the project. A number of agencies felt the BLS could have been designed at the beginning of the initiative (and added as a requirement to the contract) to ensure all Australian funded agencies were given an opportunity to use the template as a data collection and analysis tool at key points throughout the project. This data could have then been used across the country to scope agency strengths and weaknesses. This analysis would have reduced duplication of effort and promoted learning.

Annual conference or similar forums

Agencies rated conferences and similar forums as pivotal learning experiences. Project Coordinators reported coming away from the forums with greater clarity and confidence in their directions and with renewed commitment to and enthusiasm for the project – '*it was like adrenalin shot that kept going*'.

Greater clarity about the role of state peaks

The concept of funding an agency to lead collaboration and sharing of education, information and tools was sound. However, in practice the role and function of the coordinating agency was not clear from the outset. Had this role been more clearly articulated and actively pursued greater levels of collaboration may have resulted.

Funding cycles and capacity to roll over funds

> *The funding cycle of the ISI was somewhat strange and unhelpful. Before the 08/09 Budget we were given a big sum of money then two or so months later we were told if we didn't spend it by a certain date it would be taken back. At the same time we were asked for a new project plan with revised timeframes. This process happened twice. We also needed more flexibility with training funds – needed to be able to roll these funds over until we could source appropriate training and so spend the funds.*

In comments like these, the ISI agencies reflected on some of the difficulties their organisations experienced during the project as a result of funding cycle related issues. These issues were felt most acutely, when uncertainty was created among agencies and their staff about levels of funding and organisational capacity.

Acknowledging that embedding cultural change to the stage where it is sustainable takes time

There was a growing view among the ISI funded agencies that a capacity building and service development initiative like the ISI program probably needs to provide significant but tapering funding over at least a five year period if the resulting cultural change is to be embedded and sustained.

Taking the learning forward: suggestions for QNADA and other relevant peaks

A number of suggestions were made by agencies to support QNADA to take forward learning from this current cultural change project. The major suggestions included:

- Factoring in a six month development phase prior to the project's commencement on the ground in agencies;
- Engagement with Boards from the outset;
- Collaborative project planning with the agencies and/or the sector;
- Working with agencies to ensure good project beginnings;
- Sector workforce mapping and training needs analysis to aid planning for future sector wide initiatives.

Factoring in a sixth month developmental phase prior to the project's commencement

Agencies suggested that it would have been helpful if the State peaks had been able to have a six-month window of opportunity prior to the project's commencement so that they could set in place processes, resources and systems to aid collaboration and to assist agencies from the outset and prior to the project's commencement in agencies.

Engagement with Boards from the outset

A number of Project Coordinators suggested briefing sessions and packages for Board members at the commencement of the project be provided by QNADA. Comments like these reflected the importance attached by agencies to QNADA engaging the Boards of participating organisations in a greater way. The agencies suggested that Boards should be engaged from the outset of the project and be provided with succinct information and briefing opportunities at key points throughout an initiative.

Collaborative project planning with the sector and with participating agencies

Whilst acknowledging the helpfulness of the assistance provided by QNADA, agencies made a number of suggestions for sector involvement and collaboration in a new initiative from the earliest possible point. This included QNADA calling the CEOs of agencies together to explain that there was significant funding becoming available and for what purpose and to seek agency input about the way to proceed in Queensland, how the project could support sector priorities and interests and to then keep the discussion going as more information comes to hand. QNADA was seen as the advocate to the funding body for the sector.

A service agreement developed and provided by QNADA for agencies to encourage the pooling of certain resources including shared clinical governance committee arrangements, processes for staff secondments for training placements and for job shadowing, shared training opportunities, shared recruitment processes and a shared casual staff pool and access to a vetted pool of external consultants with specified expertise.

Walking with agencies to ensure good project beginnings

Agencies suggested that QNADA needed to have been in closer contact from the outset of the project with participating agencies so that they could have been aware of progress being made

and difficulties being experienced. This knowledge would in turn have assisted QNADA to play a stronger role with DOHA by providing strategic input.

Sector workforce mapping and training needs analysis to aid planning for future initiatives

A number of comments were made about the need for QNADA to undertake extensive communication with the sector as a whole and on an individual agency basis to better understand needs in the face of future challenges and to better influence government priorities and agendas.

> *The sector here is very segmented, isolated – needs to be brought together – communication needs to be facilitated about how we relate to and do business with Medicare locals, Health and Hospitals Networks, new Commonwealth mental health initiatives, preventative health initiatives, AOD grants etc. QNADA could help further by engaging the sector on important issues like these that will affect how we operate – need to get the collective wisdom and facilitate a sharing of the collective wisdom.*

In the first instance, agencies suggested that planning for future sector-wide initiatives would be aided by QNADA conducting a workforce mapping exercise and a training needs analysis.

Conclusions

The ISI enabled the eleven participating agencies to achieve a significant level of cultural change. In analysing the reasons for the success of the initiative in supporting cultural change, the agencies pointed to the enabling and flexible nature of the ISI Program.

Throughout the project the agencies were able to provide extensive opportunities for staff training and up-skilling, to develop an array of new strategic partnerships, assessment tools, case management and care coordination processes/tools and client information systems and to introduce numerous new service models, treatments and programs.

Cultural shifts observed throughout the project included:

- Enhanced professionalism and an up-skilled workforce contributing to a cultural shift placing greater value and priority on professional development and improved practice;
- A more multidisciplinary approach and greater organisational capacity to manage multidisciplinary teams;
- Improved and expanded services contributing to an organisational culture that was increasingly not afraid of change and development;
- Improved and expanded partnerships contributing to a culture that was more outward looking, more flexible and more collaborative.

Finally, a cultural shift to be more inclusive of comorbidity and complex needs was achieved which in turn contributed to holistic and integrated recovery and strengths-based models of care and to improved services and better client outcomes.

Recommendations to QNADA from the ConNetica Research Team

The ConNetica research team makes the following three recommendations to QNADA for taking forward the learning emerging from the ISI Capacity Building Program.

Recommendation One: A framework for the planning and conduct of future significant funding initiatives

That by drawing on the suggestions made by agencies, QNADA and the participating agencies collaborate to formulate a framework for the planning and conduct of similar cultural change and service development initiatives in the future.

Recommendation Two: Further development of the resource inventories with a view to their distribution and use throughout the sector

That QNADA and the participating agencies collaborate to further develop and populate the resource inventories so that the resources, tools and learning contained therein can be used to inform and support further cultural change and service development throughout the alcohol and other drug sector in Queensland.

Recommendation Three: Communication to DOHA of the importance of the Capacity Building Grants funding model

That QNADA communicate to DOHA this research project's findings concerning the importance of Capacity Building Grants funding model and the way in which it flexibly enabled and supported cultural change by providing a level of structure and guidance without being prescriptive, by being outcome-based, by providing significant resources over an extended period of time and by the funding program itself being located within a suite of complementary initiatives.