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ARTICLE

The Work and Recovery Project: Changing Organizational Culture and Practice in New York City Outpatient Services

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Topic: *Complex and multiple barriers confront out-patient programs in promoting recovery and addressing mental health recipients' work-related goals. This article describes a focused organizational change project utilizing intensive consultation and technical assistance within five New York City outpatient psychiatric services.*

Purpose: *The project aimed to increase staff exposure to, understanding and use of work-related and recovery-based concepts to promote consumers' recovery and attainment of employment goals.*

Sources used: *Tailored assessment, curriculum delivery, and identification and implementation of change objectives were useful strategies in promoting change.*

Conclusions: *This change model can serve to assist programs in their efforts to integrate new approaches and to better understand changes among leadership, staff and consumers, and changes in organizational culture and practice required to support a work and recovery-oriented service paradigm. The project experience suggests that adopting and embracing new practices takes time. Varied and incremental steps toward programmatic and operational changes can be significant and can reap authentic sustainable change occurring in the process of learning, experiencing, internalizing and adjusting to new methods of practice.*

Keywords: work, recovery, organizational change, New York

Introduction: Effecting Organizational Change

This paper reviews and assesses the Work and Recovery Project, a two-year initiative aimed at integrating work and recovery beliefs and practices into five New York City Continuing Day Treatment Programs (CDTPs). The project was premised on the assumption that organizational life and culture shape the way individuals and groups experience and interpret what they learn together and the actions they take as a result. Primarily an intentional effort to effect organizational change to impact practice directly, the project was also aimed at promoting recovery and addressing the work-related goals of mental health recipients.

Existing organizational cultures—everything from fiscal procedures to personnel appraisals—can serve as a barrier to the introduction of new principles and practices. New approaches or methods of treatment may have limited effectiveness, or fail outright, because they do not fit into the established institutional regime of values and actions. Paying attention to the introduction of a new skill set along with the effect it will have on those who are asked to integrate it into practice is critical. It is essential to recognize that the introduction of new methods and approaches will be unsettling to social systems that inherently protect themselves from the possibility of change. Stand-alone training itself does not translate to new ways of thinking and acting (Stuart, Hoge & Tondora, 2004). For organizational systems to maximize performance, the interdependence of both the technical and the social must be explicitly acknowledged and recognized: "The sociotechnical tradition of organizational development emphasizes how learning tools—the technical domain—and groups—the social domain—interact to create learning opportunities" (Hirshhorn, 1993, p. 74). Genuine organizational change is the result of an organization's ability to learn and take knowledgeable action based on its learning in an environment that can change what has been taken for granted as effective action (Argyris, 1993).

This article explains the process of consultation and technical assistance to bring about provider-level change and details the most salient experiences of five community-based outpatient programs as they shifted programming to incorporate work and recovery concepts and practices. The lessons learned in the Work and Recovery process of initiating, implementing and sustaining organizational change can inform other efforts to bring about system level change in community-based health care programs.

The New York State Context

When the New York State legislature passed the 1993 Reinvestment Act, most of the financial savings from the closures of state psychiatric facilities were transferred to establish hundreds of new community-based rehabilitation and support programs. State and local government strategic planning and funding allocations aimed to promote rehabilitation outcomes and a new commitment to work as equally important as treatment to personal recovery (New York State Office of Mental Health [OMH], 2002, 2004).

Supported employment was promoted, especially within outpatient services including CDTPs (see Bond et al., 2001). Historically, most CDTPs had little experience with delivering rehabilitation services. Although required to deliver psychiatric rehabilitation readiness assessment and development services in addition to traditional treatment services, most CDTPs, operating within regulatory constraints, continued to emphasize participants' clinical maintenance. For outpatient mental health providers committed to the values and goals of a recovery-oriented system, the challenge was to develop new and effective competencies and to improve organizational capacity to incorporate practices resulting in employment and recovery-related outcomes.

In response, the Center for Rehabilitation and Recovery of the Coalition of Behavioral Health Agencies in New York City created the Work and Recovery Project. Consistent with the Center's mandate, this organizational change initiative aimed to enhance the proficiencies of providers in New York City's mental health system and to create connections between the life goals of people with psychiatric disabilities and the skill and knowledge capacities of mental health providers. Education and technical assistance were the primary interventions used to target organizational change and to address attitudes, values, and programmatic priorities within the context of existing regulatory and funding parameters.

Initiating, Implementing, and Sustaining Successful Organizational Change

Creative thinking and increased dialogue alone do not guarantee substantive change; the pull of the dominant existing culture to return to old practice is strong. As Argyris (1993) states: "Learning in and of itself is not sufficient in order to act effectively; it is also necessary in order to codify effective action, so that it can be reliably repeated when it is appropriate. This means that effective actions are not only stored as rules in actors' heads; it means that their requirements are known publicly, usually in the form of formal and informal policies and routines that are rewarded by organizational cultures. Building policies, routines and culture requires learning" (p. 3).

Undertaking change requires commitment of significant leadership and staff time. Conscious attention and engagement are required by leadership to the process and substance of the consultation. The experience of the Work and Recovery Project is supported by relevant literature suggesting that the process of successful and sustainable change requires an interlocking linkage among related strategies and tactics (Hoge, 2004; Marrone, Hoff & Gold, 1999; Milne, Gorenski, Westerman, Leck, & Keegan, 2000; New York Work Exchange, 2002, 2004;

Rosenheck, 2001). These include assuring leadership commitment, investment and involvement in the process; engaging leaders, staff, and program participants in the change process through training and proactive program design strategies; and agency self-assessment together with learning about relevant approaches and their applicability to the particular site. Realistic expectations need to be forged regarding what is possible within a given time frame. In general, people do not change readily; time to mourn what is perceived to be given up or lost must be included within a change project time-frame, and change occurs more in a spiral than in a linear way (Harding, 2003; Marris, 1974). Unanticipated events and constraints are likely.

Leadership and Buy-In

From the inception of a change project, identified leaders must initiate and guide the project, demonstrating their availability, commitment, and readiness to facilitate implementation and sustenance of changes. Although ideas and suggestions for change can—and should—come from all organizational levels, active leadership involvement is required for change efforts to succeed. Leadership should take sufficient time at the outset to establish the context and intentions for the desired change with staff, program recipients and other relevant constituencies, allowing time for all organizational members to join the endeavor by understanding their place and stake in the process. To continue the momentum of a change process, leadership should create an institutional presence, a project name, an entity with authority (such as a steering group or project team). These are but a few examples to help assure that project status and development continue at the forefront of relevant meeting agendas.

Representatives from management, line staff, and program participants are essential members of a project team or steering group. Consumer participation promotes inclusion and responsiveness to consumer interests and concerns, enlists consumer involvement in programmatic changes, and challenges staff to work more collaboratively with consumers. Cross-sectional membership can enhance communication and bring information not otherwise readily available directly to the steering group.

Staff frequently feel burdened by additional work and responsibilities generated by a change project, even when they look forward to the outcome. Leaders and managers need to take into account impact on resource availability and staff time and energies. The experience of change also often induces cognitive dissonance—a feeling of conflict between the previously accepted way of doing things and new approaches and paradigms. Some staff may feel confused, enervated, angry, resistant, and worried, while others feel energized, enthusiastic and eager to change. Leaders—who are certainly not immune to ambivalence—need to be consciously aware of and provide guidance regarding the challenges of working within a system undergoing change. Additionally, the "revolution of rising expectations" bears conscious attention. Awareness of how much time and energy is involved in implementing change and developing a "grand design" will limit discouragement when it takes longer than anticipated—as is often the case—to launch new services, revise existing protocols, and undertake other new tasks.

Self-assessment

With or without external consultation, a period of careful self-assessment is highly recommended. Useful tools are the Recovery Based Program Inventory (Ragins, 2005), the Ohio self-assessment tool (Ohio Department of Mental Health, 1999) and an assessment format developed by Joseph Marrone and other colleagues (Marrone, 2002; New York Work Exchange, 2002). These tools enable agencies to ascertain where they stand in relationship to recovery-related issues and readiness for change. The self-assessment process can also be a way of alerting staff and program participants that change is being considered and to begin engaging them in thinking creatively "out of the box." Additionally, much can be learned from thoughtful information-gathering and communication with other systems that have already undertaken a change process similar to that being contemplated.

Focus groups are one way to seek information from various stakeholders within the organization and to initiate a unique dialogue about current and desired programs, processes, competencies, etc. Focus group data can be used to discern differences in perspectives and practice as well as to identify ideas about what and how to change. Focus groups serve to bring issues to the surface and to raise consciousness about the possibilities of change; the process of inquiry helps participants begin to examine closely held assumptions about their work and roles and the ways in which their programs are configured. Through an increased awareness of perceptions and dialogue with others, individuals can begin the process of changing beliefs and practices.

Organizational leaders may determine that outside consultation would be helpful during one or more phases of a change project, providing a perspective and knowledge about systems and programmatic structures and processes and an invaluable facilitative role as the system begins to encounter the

disequilibrium of change. It is important that a steering group responsible for the change project and the consultant(s) together map out the project goals, timelines, mutual expectations, anticipated products, etc. For it to succeed, project ownership must rest within the organization, from leadership through management, staff, and program participants.

Training

Successful organizational change requires a combination of leadership initiative, support and action for change together with staff training to develop new knowledge and enhanced competencies. In recent years, the ability to perform a particular job effectively has been articulated via competencies, comprised of skills, knowledge, and attitudes requisite to successful performance. Increased sophistication about change has been accompanied by recognition that staff and program participant training and orientation are necessary but not alone sufficient for successful change outcomes: "The usefulness at work of the education and training of an individual can no longer be divorced from the context of the work setting. It is the work team's ability to operate effectively as a group, not simply the skill level of individual workers, that determines performance" (Hirschhorn, 1993, p. 73).

The process by which training is offered can significantly affect the outcomes of training—whether information is retained, new attitudes are internalized, and new practices consolidated. Effective training requires recognition and accommodation of different learning styles (Armstrong, 1994; Felder & Soloman, 2003; Stuart, Hoge & Tondora, 2004) and a combination of didactic/explicative, experiential, and practice/application opportunities (Hoge, 2004). We recommend that agency leaders attend to providing a continuous learning environment from initiation through post-completion of such a project. The train-the-trainer model may be helpful in assuring that expertise cultivated in the agency continues to be organizationally beneficial. The training experience, if well conceptualized and delivered, can also support the evolution of effective teams.

External Forces

External forces, including though not limited to funders, regulators, legislatures, local government, political realities, and unanticipated crises constantly impinge on an organization. In New York State, the impending implementation of PROS (Personalized Recovery Oriented Services) is a case in point (OMH, 2007). In the context of PROS implementation, the premises and practice of the Work and Recovery Project have set the stage for changes that may be on the horizon for many CDTPs. Awareness of these forces is necessary while leaders concurrently support and promote change. The impact of external forces on a change project cannot easily be predicted or controlled. Turbulent external environments may significantly affect capacity to move forward. On the other hand, external mandates may lead to organizational changes that might not otherwise have occurred.

Project Activities

The Work and Recovery Project began in July 2002 and ended in June 2004. The Center for Rehabilitation and Recovery developed a Request for Proposal circulated to CDTPs serving adults in New York City. A committee of representatives from the Center and the New York State Office of Mental Health reviewed the proposals and selected five sites: three diverse locations in Manhattan, one each in the Bronx and Queens.

Each site received tailored, on-site technical assistance and consultation with CDTP leadership, managers, program staff and consumers for about nine months. Consultation and technical assistance were aimed at promoting consumers'[1] recovery and attainment of employment goals through the introduction of work-related and recovery-based concepts and activities. Two project consultants worked together at the first site, shared the assessment phase at all sites, and worked individually at two of the remaining four sites.

Generic targeted outcomes and benefits for all sites included: the incorporation of work and related content into CDTP programming; increased staff skills and knowledge in areas of recovery and employment; improved integration and collaboration among existing agency employment and clinical services; CDTP consumer assessments with vocational and related elements; treatment plans and progress notes containing increased references to work and related options; increased CDTP consumer requests for employment-related experiences; increased consumer referrals to clubhouses and employment services; increased intra- and interagency collaboration; and a CDTP support network to link employment-related community partners and revise policies and procedures to reflect the employment needs of consumers. Each site also identified site-specific outcomes.

During the site assessment phase, the consultants conducted on-site focus groups and interviews with CDTP and parent organization management, clinical and line staff, and consumers, to assess current and desired work related services within the CDTP system. Four out of five sites enlarged the scope of the Work and Recovery Project beyond the CDTP to include

participation from other agency programs involved in the provision of relevant care and services.

Based on the assessment, consultants designed and presented a six-session on-site curriculum to CDTP leadership, line staff and consumers with didactic, experiential, and application components. Up to twenty staff participated in six two-hour curriculum sessions on issues such as recovery, best practices for employment, integration of clinical and employment services, creation of partnerships to promote employment options, elements of a cultural shift necessary to integrate employment within the existing delivery system, and how to initiate and sustain organizational change. Training participants were given readings and "homework" assignments between sessions.

During the third phase, four to six months per site, a smaller project team was constituted, averaging eight members including staff from all levels and program participants, with the consultants serving as resources. The project team worked to translate learning into practice, discussing and overseeing the implementation of specific outcomes on behalf of the system/agency. Project team members also convened subcommittees, developed revised documents and forms, worked with their colleagues to create and implement new program activities, and in some instances designed and offered training for staff not previously involved in the Work and Recovery Project.

The fourth and final phase consisted of follow-up and networking among participating CDTPs as each site completed its project period. On-site follow-up at each CDTP was conducted one or two months post-completion to reflect on learning, to take stock of programmatic changes, to assess outcomes and to plan for next steps. Project team members organized the meeting, prepared an agenda and handouts, and participated in the two-hour meeting. Some sites also hosted a networking meeting with representatives of all five sites. At these meetings, the host site described the project at the respective site, its impact on programs and staff, changes underway, and offered a site tour.

Lessons Learned

At all five sites generic outcomes set by the Work and Recovery Project were attained. Outcomes differed from site to site, based in part on the goals and objectives set by the sites themselves and by their success at implementing changes. Consumer-based outcomes were not quantified. Analysis was based on the self-reporting of the site providers and the authors' observations.

The most salient examples of changes evidenced at the five different sites are presented below. The appendix delineates these changes, categorized in relationship to: shifting programming toward work and recovery; promoting teamwork and collaboration among programs; increasing staff skills, knowledge and role development in areas of recovery and employment; and increasing intra and interagency collaboration. These changes are iterative, not discrete, and reflect the interdependence necessary for sustainable change in culture and practice. Some examples of change are small and incremental; others are substantial in terms of resource allocation and institutional trajectory. A more complete assessment of the impact and sustainability of these changes can only occur over a longer time period.

Shifting Programming Toward Work and Recovery

Direct programming efforts are usually the most difficult changes to initiate and sustain. The Work and Recovery effort challenged assumptions about consumer, practitioner and system relationships to recovery and led to new learning about unintended effects the system and its culture have on practice. Practitioners and consumers were able to identify restrictions caused by systemic regulations and arbitrary role distinctions as well as a wealth of resources previously unavailable to individuals and systems.

Examples of sustainable service delivery changes include attention to vocational issues at initial intake through the use of vocational screening and assessment forms; initiation of groups focusing on employment readiness, seeking, securing and sustaining employment; development of a survey to determine the services and resources consumers desired to assist in their recovery; plans to establish a consumer resource center and to teach job skills in a new CDTP site where computers and work stations could be available to consumers seeking competitive employment; arranging for CDTP consumers to participate in work activities for a portion of the day; and developing an in-house supported employment/transitional employment project.

Numerous apparent correlates for consumers securing and maintaining competitive employment emerged across the five Work and Recovery Project CDTP sites. These included working with consumers flexibly at different phases of vocational involvement; providing a robust transition from interest in work to the acquisition and integration of work in participants' lives; offering access to resources internal and external to the agency that provide empowering experiences for consumers; assuring effective and efficient external linkages and collaboration; assisting staff to be better equipped at targeting skill and role

development with consumers; exploring recipients' interest in work at initial assessment, followed by a more in-depth exploration at intake; and addressing attitudes as staff members engage consumers in seeking employment.

Promoting Teamwork and Collaboration Among Programs

Four of the five sites expanded the scope of the consultation beyond the CDTP to include those programs within the system with significant roles in employment-related services. These often included case management, outpatient and existing work services programs, whose staff also recognized limitations in their ability independently to provide for consumers' work and recovery needs. The inclusion of other services in this project was strongly supported, given that change in one part of the system can influence and inform other parts of the system.

Changes resulting from increased collaboration included: development of committees across programs to infuse work and recovery practices for consumers served by more than one program; creation of alliances among several agency programs to develop and support possible vocational endeavors; more focused and frequent interdepartmental conversation and attention to staff roles; realignment of services for those with co-occurring disorders; more focused vocational attention through assessment and peer support; establishment of an administrative group to oversee and direct interdivisional efforts, diminishing the influence of divisional silos; and establishment of agency-wide planning to increase employment-related assessments.

Increasing Staff Skills, Knowledge and Role Development in Areas of Recovery and Employment

Mental health practitioners are often placed in the role of experts vis à vis their clients. A recovery model requires practitioners to be in relationship to consumers in a non-expert role and requires consumers to expand views of self in relationship to their mental illness. The Work and Recovery Project encouraged practitioners to involve consumers every step of the way in their recovery and service provision. As a result of their experiences of working to internalize a new set of skills and cultural shift in their work roles, some staff persons expressed need and desire for additional training both for themselves and for staff not included in the Work and Recovery Project training.

Examples of attention to staff development at project sites included seeking grants for ongoing staff training in enhancing competencies in areas of work and recovery; expanding training in work and recovery concepts to agency staff to broaden the dialogue agency-wide and teach new competencies to staff whose programs interfaced with the CDTP; assessing and responding to attitude change among staff; and providing training opportunities facilitated by consumers.

Increasing Intra and Interagency Collaboration

Leadership and staff at each site reported past difficulties in designing and implementing vocational services that would "take hold" organizationally and be responsive to consumer needs. The reasons underlying this difficulty are complex and multi-determined. Traditional mental health services were shaped at a time when the consumer's voice was not sought, leaving staff and administration to create more prescribed and one-sided service delivery systems. Also, services were and often continue to be developed and offered in isolation, with limited flexibility and responsiveness to consumer needs, with ongoing variability and interdependence of providers as consumers move among services. Funding sources for these programs also reinforce this isolation with discrete and conflicting program criteria and priorities. The resulting structural disincentives restrict access to care and prevent more system-wide flexibility and interdependence in program design and delivery. These constraints perpetuate more traditional service delivery, despite strong evidence indicating that a more integrated, flexible and individualized approach supports ongoing and successful recovery (Stuart et al., 2004).

In spite of the numerous and complex obstacles to integration, evidence of increased intra and interagency collaboration at the Work and Recovery sites included provision of multi-family groups to engage partners in consumers' recovery process; linkages with internists for consumers' medical care; initiating and continuing an interdivisional leadership and coordination group; and constituting work and recovery teams to continue implementing identified outcomes and developing new goals. Leadership support and action were essential in mobilizing intra and interagency collaboration.

Conclusion

A project of the scope and extent of the Work and Recovery Project must be viewed as an institutional change effort, rather than primarily as a training event. Effectively integrating recovery within a service delivery system demands a complex marshalling of an organization's resources. The challenges entailed in promoting and instituting recovery-facilitating services and in joining employment-oriented with clinical practice require an unprecedented collaboration and shift in orientation among staff trained in significantly different paradigms. This shift can only occur once organizational members share an understanding of how organizational life and culture shape individual and group experience

and interpretation of learning. With this understanding, clients, staff and leaders can together begin the process of developing new ways of engaging and working together to evolve a new cultural paradigm.

Additionally complex, yet necessary, is the work of helping all those who participate in such a project to "find their own way" in the work, searching for conceptual and personal integration of recovery in individual practice and experiencing anew the power of a collaborative relationship. This process was aided in the Work and Recovery Project by reflecting upon personal assumptions and beliefs about the nature of recovery and the organizational pull to perpetuate client dependency on the clinician and the system. Participants began to experience the authority of their role in effecting change to a more collaborative practice model.

The Work and Recovery Project was useful in guiding sites regarding the impact of organizational culture on service delivery. The focus on recovery, along with the project's collaborative and exploratory design, provided opportunities to engage in institutional change, clarify roles, and broaden dialogue and consideration of links between consumer empowerment and staff work satisfaction. The Work and Recovery Project led to greater confidence and competence among leaders, managers, staff and consumers regarding recovery from mental illness and work as a key element of recovery.

1 We recognize the lack of agreement and the variety of terms used to refer to individuals with mental illnesses who receive services. These include consumer, client, patient, consumer/survivor/ex-patient, recipient, program participant, and person in recovery. We generally use "program participant" or "consumer" in an effort to label as little as possible while describing individuals' relationships to the respective programs. We anticipate that terms will continue to evolve as emphasis on recovery oriented services increases.

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Appendix–Work & Recovery Project Activities and Outcomes

A. Shifting programming toward work and recovery

- Conducted vocational screening and assessment during intake process.
- Established groups focused on employment activities.
- Developed a consumer survey to identify services and resources that promote recovery.
- Planned to create a Consumer Resource Center including job skills training and computers for online job searching.
- Modified programming to support consumer participation in external work activities.
- Established an in-house supported employment/transitional program.

B. Promoting teamwork and collaboration among agency programs

- Established committees to implement recovery principles and practices across programs.
- Increased multi-agency collaboration around vocational endeavors.
- Formalized interdepartmental discussions focused on shifting staff roles.
- Re-aligned services to include those with co-occurring disorders.
- Empowered an administrative group to oversee and direct interdivisional efforts.
- Initiated agency-wide planning to increase employment-related assessments.

C. Increasing staff skills, knowledge and role development in areas of recovery and employment.

- Sought grants for ongoing staff training in areas of work and recovery.
- Expanded training to other program staff.
- Provided training opportunities facilitated by consumers.

D. Increasing intra and interagency collaboration

- Delivered multi-family groups to engage partners in recovery process.
- Established linkages addressing consumers' medical care needs.
- Constituted standing committees to continue interdivisional communication and project efforts.