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Organisational change to integrate self-management into specialised mental health services: Creating collaborative spaces

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Abstract

Introduction: Self-management support for schizophrenia has become expected practice leaving organisations to find ways for feasible implementation. Self-management support involves a foundational cultural shift for traditional disease-based services, new ways of clients-providers working together, coupled with delivering a portfolio of tools and techniques. A new model of self-management support embedded into traditional case management services, called SET for Health (Self-management Engaging Together for Health), was designed and tailored to make such services meaningfully accessible to clients of a tertiary care centre. This paper describes the proof of concept demonstration efforts, the successes/challenges, and initial organisational changes.

Method: An integrated knowledge translation approach was selected as a means to foster organisational change grounded in users' daily realities. Piloting the model in two community case management programmes, we asked two questions: Can a model of self-management support be embedded in existing case management and delivered within routine specialised mental health services? What organisational changes support implementation?

Results: Fifty-one clients were enroled. Indicators of feasible delivery included 72.5% completion of self-management plans in a diverse sample, exceeding the 44% set minimum; and an attrition rate of 21.6%, less than 51% set maximum. Through an iterative evaluation process, the innovation evolved to a targeted hybrid approach revolving around client goals and a core set of co-created reference tools, supplemental tools and resources. Operationalisation by use of tools was implemented to create spaces for client-provider collaborations. Monitoring of organisational changes identified realignment of practices. Changes were made to procedures and operations to further spread and sustain the model.

Conclusion: This study demonstrated how self-management support can be implemented, within existing resources, for routine delivery of specialised services for individuals living with schizophrenia. The model holds promise as a hybrid option for supporting clients to manage their own health and wellness.

KEYWORDS

knowledge translation, mental health services, organisational change, self-management

1 | INTRODUCTION

The development and evaluation of self-management support for schizophrenia has gained importance with the recognition of self-management as a practice expectation in quality standards for community care[1] and mounting evidence substantiating routine delivery.[2,3] Self-management support delivered as a collaborative client-provider partnership, driven by client recovery goals, is viewed as one strategy to address inequities in healthcare, and improve health outcomes.[1,4] Issues remain surrounding access to self-management support and the feasible delivery within existing resources, particularly for those living with schizophrenia and comorbidities.[5]

We aimed to develop a model of self-management support embedded in a recovery-oriented framework to enable accessible, feasible delivery with community living adults diagnosed with schizophrenia. We refer to self-management support as healthcare providers, working in collaborative client-provider partnerships, supporting clients to possess the knowledge, skills, self-efficacy, resources and supports to participate in self-management (i.e., engage in healthy behaviours to manage or reduce the impact of health conditions on daily life in the context of their living situation while living a meaningful life). The rationale, literature review, planning, preparations and decision-making behind creating a model of self-management support embedded in existing case management services specifically tailored to individuals living with schizophrenia, called Self-management Engaging Together (SET) for Health, is described in detail separately.[5] This paper describes the process of implementing and refining SET for Health at a tertiary, public mental health centre in Ontario, Canada where self-management support is now included as a standard of community care for adults with schizophrenia. The questions asked: Can a model of self-management support be delivered and embedded in existing case management-based specialised mental health services? What organisational changes are required to support successful implementation?

2 | METHODS

2.1 | Design and theoretical framework

Implementing self-management support involves a cultural shift from disease-based care while delivering a portfolio of tools and techniques.[6] During planning, we implemented an integrated knowledge translation (IKT)[7] approach to foster organisational change at the level of the programme. IKT was selected to leverage self-management users' knowledge and commitment to further the project's aims. Further, IKT was viewed as an essential element for implementing and sustaining what is in essence a complex social ecological intervention. IKT can support the social construction, negotiation, ascription of meanings to experiences, and revisioning of knowledge, understandings necessary for new ways of working and cultural change. Further details of study design, framework and context are described separately.[5]

A mixed methods study was planned to provide both quantitative and interpretive phenomenological qualitative data to evaluate the programme. The quantitative data were to inform accessibility (client sample characteristics), and feasibility (dropout and completion rates). Further quantitative data were collected as part of the larger study to examine the suitability of outcome measures (self-management, social and occupational function, illness severity, quality of life, hope, and will be reported in a future paper. The qualitative data (casebook audits, interview transcripts, practice observations and anecdotal feedback) were to explore experiences, perceptions and to understand the value, impact of the intervention from client and provider perspectives in the tradition of van Manen.[8] Nesting the quantitative within the primary qualitative component, supported understanding how the model of delivery worked in the practice context; that is, what changes were made to practice and to the intervention, what was working/not working, suggest therapeutic elements and mechanisms of action.

The mixed methods supported a sequential triangulation of information synthesized by a research question at different stages of implementation.[9] At this initial stage, casebook audits supplemented on-site observations, anecdotal reports, and at a later stage, client and provider interview transcripts, were evaluated to offer the context and user experiences and insights within which to further interpret and understand questions of accessibility and feasibility. In situations when the quantitative data appeared inconsistent with the qualitative data, neither data was dismissed or discounted; rather, understood to be capturing different aspects or dimensions of the parameters. Emerging patterns, and inconsistent findings were discussed for triangulation in research team meetings, and sometimes brought to front-line staff and clients for validation and elaboration.

The larger study received approval from the Hamilton Integrated Research Ethics Board, study #3733, and informed written consent was obtained. This paper will report accessibility and feasibility findings, initial revisions to the intervention, and changes in the organisation to support implementation. Further findings from interviews at 1 and 2-year evaluations as well as quantitative findings of outcome measures are planned for subsequent papers.

2.2 | SET for health—the vision, provider training and support

The initial vision of *SET for Health* was described as therapeutic procedures to be recognisable by all providers and operationalised by the use of selected facilitation tools (Figure 1). 'SET' referred to Self-management **E**ngaging **T**ogether **for Health**. To prepare, multi-disciplinary providers participated in two half-day workshops followed by 10 monthly 1-hour education and collaboration sessions facilitated by authors S. S., M. M. and H. M. These sessions were designed to reflect on values and beliefs; mobilise expertise; foster confidence in self-management conversations, promote coaching opportunities; and activate integration into routine practice. Sessions reinforced the message of learning together and that the self-management learning

PROCEDURES	FACILITATION TOOLS
Module 1: Client & Family/Carer Engagement & Alliance	
• Orientation	Script of roles, approach My Back-Up Plan
• Concerns & needs of clients/families/carers	Health Concerns Bubbles by Client Illness Management & Recovery Scale - Families/Carers
• Assessment of client strengths & supports re: self-management	Multidimensional Scale of Perceived Social Support Partners in Health Scale
• Client values & meaning of recovery	Values Clarification Worksheet Visions of Recovery Statements
Module 2: Collaborative Goal-Setting, Action Planning, & Client-Provider Reviews	
• Negotiate goals & plan actions with client, family/carers & support network	Recovery Plan
• Weekly client goal setting, motivational strategies, review & problem-solving	Personal Action Plans
Module 3: Self-Management Education, Coaching & Support for Clients & Family/Carers	
• Health literacy • Guided discovery of wellness & illness/life management strategies • Use of local resources/supports	Stress Vulnerability Model Self-Management Education Materials
Module 4: Self-Management Plan Development, Use, Refinement	
• Wellness strategies • Early warning signs & coping strategies • Red flags of relapse & actions by client & others • Communicate & negotiate with support network	Self-Management Plan & revisions

FIGURE 1 Initial vision of Self-management Engaging Together for Health Model

process be given priority over task completion. Workshop topics were adjusted flexibly to address practice challenges that emerged. Between workshops, providers were provided support on demand with coaching and demonstrations by S. S. and M. M. As provider champions emerged as role models, mentorship was encouraged. The on-site manager, A. G., provided on-going support, recognition of learning efforts, and trouble-shooting.

2.3 | Implementation and data collection

Providers were asked to use SET for Health with all clients on their caseloads. The decision of who to select for inclusion first was given to the providers while gaining experience. As confidence grew, providers were encouraged to challenge ideas of who may engage and benefit. With no exclusion criteria, other than the registered clients of the programme be English speaking, those clients interested in SET for Health were invited to participate in the study, meeting with researchers to obtain written informed consent.

The first and fourth authors audited provider progress notes, and tool use guided by a SET for Health Fidelity Scale, adapted from the Illness Management and Recovery (IMR) Treatment Integrity Scale IT-IS,[10] supplemented by observations of providers in practice. In particular, audit fieldnotes documented language used, orientation to clients, references to client self-management and provider self-management practices. The audits offered glimpses, concrete suggestions of changing practices and remaining challenges over time. Further, reviewing completed tools (e.g., self-management plans) with annotated client comments coupled with progress notes provided evidence of actual practice in real time and prompted areas of focus in education sessions. The progress notes were understood to

incompletely portray self-management client-provider encounters. However, importance was given to documented behaviours illustrating self-management support within a recovery framework. Arising findings indicating change, integration and tensions/challenges regarding implementation of the new model were further reflexively explored in iterations of additional audits, observations and conversations in provider education sessions, and team meetings. In this iterative manner, the analysis of qualitative data occurred concurrently with data collection, and implementation practices were shaped by data collection.

To support reflection and documentation, first author kept a journal for the 10 months of provider education sessions noting after each session participant feedback, items of resonance and learning, and observations of integration into practice. Also, notations were made reflecting on hallway conversations or providers dropping in to excitedly share a new learning, accomplishment, or vent frustration. Providers were encouraged to share these learnings/concerns with peers at future education sessions. The third author, as manager, shared observations, expressed concerns. At monthly research team meetings, minutes captured discussions of arising themes. Some research team meetings were devoted to summarizing team members' observations and questions.

2.4 | Data analysis

2.4.1 | Can a model of self-management support, SET for health, embedded in existing case management be delivered in the context of specialised mental health services?

Using IMR programme benchmarks[11] from participants with severe and persistent mental illness, a priori indicators of success included: (A) attrition rate ≤51% of drop-outs; (B) completion of self-management plans ≥44%; and (C) an operationalised SET for Health Model.

2.4.2 | What organisational changes support implementation?

This question was answered by triangulating descriptive summaries from casebook audits, programme materials, researcher observations and anecdotal reports from care providers, and manager encompassing the innovation development process.

3 | RESULTS

3.1 | Participants, attrition and completion rates

Two community-based case management teams located within an outpatient hospital environment provided the setting; a transitional programme that bridges clients discharged from tertiary schizophrenia inpatient admissions, and a standard schizophrenia outpatient programme that provides community outreach with clinic-based services of variable intensities. The pilot began with the transitional programme's complete provider team (five registered nurses, one occupational therapist) and three provider participants from the outpatient programme (one registered nurse, one occupational therapist and one social worker). The latter three providers were invited to participate by the manager after identifying early adopters and leaders. Three nurses and one occupational therapist left during the study period and were replaced by providers of the same healthcare discipline.

Providers trialled the innovation with a total of 51 clients. Another three clients expressed interest but were too acutely ill or markedly cognitively impaired to participate. Of the 51 enroled, 11 clients did not receive the intervention: 5 were withdrawn for acute medical issues or significant substance use, 3 moved, 2 left the mental health service, and 1 died of long-standing medical conditions. Therefore, 78.4% (40/51) of participants received the intervention of varying intensity of exposures with 21.6% (11/51) attrition. Three participants did not complete the core three reference tools due to medical issues interrupting delivery for a 72.5% (37/51) retention rate to completion of self-management plans. Both retention and attrition rates were better than the a priori benchmarks.

Table 1 illustrates the diversity of participants who received the intervention. For half (21/40, 53%), illness onset began early (8–17 years of age) with 47.5% (19/40) having 4–9 lifetime hospitalisations. For the majority at baseline, community tenure was ≤12 months (27/40, 67.5%), and they knew their provider <5 months (25/40, 62.5%). Only 25% (10/40) had been with their provider >1 year.

3.2 | Operationalised delivery of SET for health

As depicted in Figure 2, the facilitation tools were stream-lined to: (A) core required components to be offered to all clients (Stress Vulnerability Model of psychosis in a recovery framework,[12] Partners in Health Scale,[13] Self-Management Plan, IMR Scale[14] adapted for families); and (B) additional resource tools for clarification, motivation, and information to assist pursuit of recovery goals (adapted Values Clarification Worksheet,[15] Personal Action Plan, Multidimensional Scale of Perceived Social Support,[16] adapted Visions of Recovery Statements,[17] Wellness pamphlets (www.heretohelp.bc.ca), and information modules from standardised programmes (e.g., I-IMR[18]).

Clients completed, at minimum, the three core reference tools taking 3–13 months. The longer time frames were related to interruptions in service delivery secondary to acute physical illnesses and/or changing social conditions (e.g., death in family, change in housing, bedbug infestation).

3.3 | Care process and organisational changes

Over the course of the study, self-management was being integrated in the language and practice procedures of the larger clinical setting

TABLE 1 Sample characteristics

Characteristic	Distribution of attribute in sample ($n = 40$)
Sex	Women ($n = 22$), men ($n = 18$)
Age	Range 22–73, mean 46.58 (SD 12.61) years
Education achieved	Mean 13.28 (SD 2.8) years
Marital status	Single ($n = 26$), separated/divorced ($n = 9$), married/cohabitating ($n = 5$)
Living situation	Assisted living ($n = 17$), with family ($n = 12$), alone ($n = 11$)
Age of illness onset	Mean 18.8 (SD 6.6) years
Lifetime hospitalisations	Mean 6.38 (SD 7.37)
Community tenure	Range 0–24 years, mean 32.4 (SD = 59.07) months
Primary diagnoses	Schizoaffective disorder ($n = 21$), schizophrenia ($n = 17$), delusional disorder ($n = 2$).
Secondary diagnoses	Substance use ($n = 12$), anxiety or depression ($n = 10$), learning disability ($n = 5$), developmental disorder ($n = 4$)
Medical conditions	31/40 (77.5%) were concurrently treated for 1–7 medical conditions including: cardiovascular disease, respiratory and endocrine disorders, acquired brain injury, Parkinson's

Abbreviation: SD, standard deviation.

from referral to discharge as depicted in Figure 2. They began requiring referrals to include clients' personal goals. Before registration, clients were invited to a group Orientation Session with slides introducing the programmes, the approach, and services including self-management. The orientation was framed as a time to ask questions to decide for themselves if services were right for them. Then, individuals and family attended an Intake Meeting with a rotating nurse and allied health provider, where after a biopsychosocial history, they reviewed available services aligning with individual needs and goals. Clients were then asked what they do to manage their own health and illness and how they would like to be supported ('What keeps you healthy, living well and strong? What happens when you become unwell? What do you do on "bad" days? What would you like other people to do when you are unwell?'). Clients/families were asked if they were interested in learning about self-management ('Are you interested in learning more about what you could do to live well in addition to taking medications?'). Next, they were assigned a case manager and a psychiatrist for on-going follow-up. During a medication and medical review, conversations were held about medication management and healthy lifestyle. Afterwards, on-going client-case manager meetings were held weekly or bi-monthly to pursue recovery goals on-site or in the community interspersed with psychiatrist meetings.

Changes were made to programme forms and documentation processes to support new practices related to SET for Health. For example, prompts were added to electronic health records to cue Intake providers to record client answers as to how they managed their health and illness, how they would like to be supported, and their interest in learning about self-management. The manager embedded self-management into supporting structures such as: hiring processes (asking provider applicants their understanding of self management, how they elicit client engagement and participation, and how they would build self-management capacity during interview scenarios); performance reviews (asking how they have engaged, worked with families to build self-management capacity, how they integrated SET for Health into practice); information sharing with healthcare organisations (client self-management plans accompany discharge summaries); and on-going access to continuing provider self-management education and support.

During education sessions with provider study participants, hallway conversations and larger clinic team meetings, providers were engaged in discussions about integrating SET for Health into the tasks of a case manager (e.g., mental status assessments, safety checks, metabolic monitoring, medication delivery). Providers' creative integration of self-management conversations, and efforts to tailor the approach to clients' learning needs were recognised. Exemplars were repeatedly referenced by champions, the manager, and in education sessions. Similarly, use of reference tools to deal with crisis, support care planning or delivery, and to support client self-determination and capacity-building were acknowledged.

Audits revealed changes in documentation. Health behaviours were targeted, and described objectively with less labelling. Client voice was described and quoted more frequently. Progress notes contained goal focused activities and life challenges together with mental status, medication adherence, and safety checks. Notes concluded with actions for follow-up by both provider and client (previously provider only). Each of these were interpreted as indications of integrating self-management support into practice.

Observations of programme team meetings and provider-client interactions revealed broader emphasis on a strengths-based

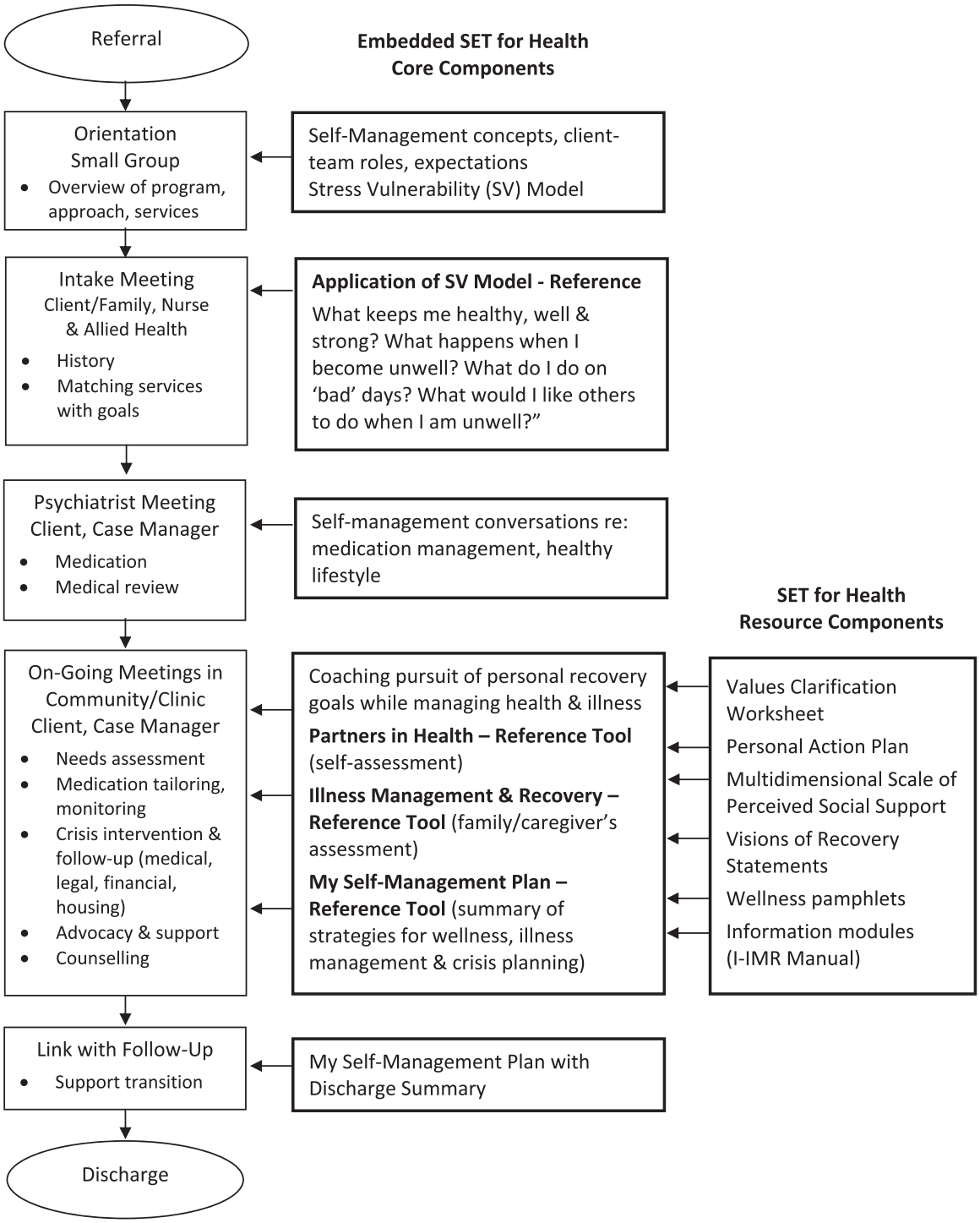

FIGURE 2 Refined SET for Health Model integrated into care process.

approach with clients. Providers expressed more positive views and pursued problem-solving to examine issues. Discussions were more structured during client contacts. There was evidence of more preplanning, preparation to incorporate tools and reflections on practice. Story telling of experiences demonstrated when and how providers were using the tools. These observations indicated work was aligning with self-management support.

4 | DISCUSSION

4.1 | Summary

This paper described efforts to make self-management support accessible to clients living with schizophrenia and comorbidities by embedding a new model, called SET for Health, into traditional case

management services. The innovation was both the development of an accessible, feasible self-management intervention and the embedding into a traditional medical model of outpatient care. An IKT approach was used to foster organisational change. Implementation was operationalised by client-provider coproduction of reference tools to create a collaborative space for self-management conversations. Providers engaged and implemented SET for Health demonstrating delivery with a diverse group of participants. Retention (72.5%) and attrition (21.6%) rates were better than the benchmarks documented in the self-management literature with severe and persistent mental illness. Through an iterative evaluation process, the innovation identified a core set of reference tools, supplemental tools and resources. Changes were made to procedures and operations to further spread and sustain the model. This project demonstrated how self-management support can be implemented, within existing resources, for routine delivery of specialized services for individuals living with schizophrenia. The refined SET for Health was co-designed by researchers, service providers and clients, and applied to become a practical and meaningful intervention to support people living with schizophrenia and other comorbidities to manage their own health and wellness.

4.2 | Organisational change implications

Priority must be given to providing self-management support as an essential service. Self-management is a resource for self-determination and living well with mental illness, a capacity to be developed and supported.[19] This paper provides an exemplar of how a conventional specialized mental health service acted to operationalize policy that self-management support routinely be given priority. We intentionally created spaces in processes of care for clients to use, learn and practice self-management. By embedding in operational processes, we can to some extent counter practice returning to the status quo.

The SET for Health Model is offered as a product customised to facilitate provider behaviour change at the programme level. The model represents a knowledge translation product for teaching different regulated healthcare providers to deliver individually tailored self-management support within a recovery orientation. By operationalising the intervention as client-provider coproduction of key reference tools, baseline fidelity of delivery was supported. Also, operationalisation by use of tools facilitated development of new provider behaviours, and the realignment of daily practice.

The model's refinement to core components delivered to all clients, and additional resource tools directed by clients' recovery goals, provided sufficient structure to give direction, and ensured a level of standardisation, while allowing sufficient flexibility to meet clients' needs, and different providers' ways of working. The balance supported adoption into practice. This is what others described as a 'fuzzy periphery'; an important attribute to enable programmes to operationalise into routines and transfer from one context to another.[20] The SET for Health Model offers a hybrid option to standardised self-management curriculums. Support was provided by a resource intensive study[21] published after the launch of SET for Health. They reported limited value from trying to integrate a standardised curriculum, and suggested a more targeted hybrid approach to delivering self-management support, focusing on topics specific to clients' goals; an approach similar to SET for Health.

4.3 | Practice implications

Barriers were encountered regarding providers' perceptions, beliefs and openness to examine practice. Initial reactions of 'this is just client-centred practice and what we already do' undermined provider engagement. Discussions were held during education sessions about change being difficult. In some instances, providers were seeking a mental image of what practice may look like delivering self-management support. Provider champions were asked to articulate how practice was different drawing on examples coupled with positive client feedback. Discussions with colleagues helped reframe interpretations of experiences. The manager communicated the status quo was to change, and staff had a role in shaping the implementation. There were staff who left or retired. Shadows of paternalism and gatekeeping were expressed as 'worrying' that is, that these new activities would negatively impact relationships with clients or may result in client failure. This response echoes other studies of provider behaviour change interventions for clients with long term health conditions.[22] Reticence to approach clients with self-management conversations until the provider deemed the client ready began to reduce as providers observed clients engaging with the reference tools. As provider comfort and confidence grew, and demonstrations of client participation were at times contrary to expectations, providers demonstrated increased openness to engage, and try more facilitation tools. For some, assistance was needed to problem-solve integration into routine tasks or reverse engineer tasks.

Despite gains, a small proportion of providers demonstrated more limited uptake of practice changes. Reasons included perceptions of increased workload, and being focused on short-term gains. In education sessions, an acknowledgement was expressed that this is a different way of working; with a long-term view, an initial investment of time would mean later working differently with self-determining individuals with less intensity of service over time. In part, the issue was committed providers feeling obliged to shoulder responsibility for clients' well-being rather than viewing self-management support as a shared endeavour with shared responsibility, respecting self-management as the client's work. For some being asked to view this approach as a joint learning process, contrasted with task-based work routines. Further, there were systemic tensions with delivering a capacity-building intervention of self-determination, personal growth and discovery within a healthcare system that tended to place priority on minimising risk, and obligations to protect the vulnerable; hence fostering client dependency rather than capacity-building. Coproduction of self-management plans facilitated proactive collaborative planning and risk management; offering a strategy for addressing providers' and families' fears.

4.4 | Strengths and limitations

The initiative has yet to be implemented in an independent setting. However, meaningful organisational change at the programme level is evident. Findings are based on a rich triangulation of information from multiple methods and sources that examined change as it was happening. The IKT design enabled the end product, SET for Health, to be co-designed and tailored to the work context. This study is the beginning of an on-going, evolving change process.

5 | CONCLUSIONS

A model of self-management support was operationalised and delivered successfully for individuals living with schizophrenia and other comorbidities during routine service delivery. Collaborative spaces were supported by client-provider cocreation of reference tools. Findings offer strategies for organisational and provider practice change, and inspire continued evaluation of a hybrid option for supporting clients to manage their own health and wellness.

AUTHOR CONTRIBUTIONS

All authors participated in the conceptualization and design of the investigation and reflexive analysis; all contributed to discussion of the main focus and this paper's ideas; all reviewed, edited and approved final manuscript. Susan Strong as PI, took a lead role in the conception and design of the study, took lead in applying for and acquired funding, and directed the study; conceived the innovation; and prepared the first draught of the manuscript. Lori Letts helped design the study, contributed to interpretation of results and conceptualization of the manuscript and contributed to writing. Alycia Gillespie assisted study administration, acquisition of resources, interpretation, visualisation and operationalisation of the innovation, and contributed to writing discussion section. Mary-Lou Martin assisted provider training, data collection-audits, interpretation and editing draught manuscript. Heather E. McNeely assisted in conceptualization of the project, contributed to provider training, interpretation of findings and contributed to revisions of the draught manuscript.

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CONFLICTS OF INTEREST

Portions were part of first author's PhD dissertation. The first, third, fourth and fifth authors declared potential conflict of interest with respect to research, given employed by St. Joseph's Healthcare Hamilton, and no conflicts of interest with respect to authorship and/or publication. The third author is manager of study site. The second author was a PhD Committee member, and declared no potential conflicts of interest.

DATA AVAILABILITY STATEMENT

Data available upon request.

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